Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02200

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland; LENGTH OF STAY (in this place):	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 151 N. Mechanic St.,	STREET ADDRESS (If rural, give location): 151 N. Mechanic St.,

3. NAME OF DECEASED (Type or Print): (First) ANNIE (Middle) HELEN (Last) ADAMS

4. DATE OF DEATH: (Month) Mar. 7, (Day) (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: ? 1878

9. AGE last birthday: 71 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: Welfare Worker

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Alexander Adams

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service):

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Mrs. Alex. Adams 320 Cumb. St., (Sister-in-law)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) acute coronary occlusion	6 hours
475 Antecedent cause(s)		
9.1a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) upper respiratory infection	2 days
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-7-, 1950, to 3-7-, 1950, that I last saw the deceased alive on 3-7-, 1950, and that death occurred at 7:25 P m., from the causes and on the date stated above.

SIGNATURE: L. Bruns (Degree or title): MD ADDRESS: 57 Greene St. DATE SIGNED: 3-9-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE: 3/10/50 NAME OF CEMETERY OR CREMATORY: Rose Hill Cem. LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: March 10, 1950 REGISTRAR'S SIGNATURE: A. R. Frantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 14 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02201

Reg. Dist. No. 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Flintstone; LENGTH OF STAY (in this place) 56 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Flintstone; STREET ADDRESS (If rural, give location) R#2

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Enoch (Last) Alt

4. DATE OF DEATH: (Month) March (Day) 13 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Nov 22 1865

9. AGE last birthday: 84 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Owner Farming

11. BIRTHPLACE (State or foreign country): Grant County, W. Va.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Martin Alt

14. MOTHER'S MAIDEN NAME: Saphrona George

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Dayton Dolly, Flintstone, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis — Interval Between Onset and Death: 5 yrs

420.1

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

934

(b) Coronary Sclerosis — 5 yrs

(c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 3 1950, to March 12, 1950, that I last saw the deceased alive on Mar 12, 1950 and that death occurred at 5-40 pm. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Benedict Skatarlic R2 Cumberland Md.

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: Mar 16 1950

NAME OF CEMETERY OR CREMATORY: Glendale Cemetery

LOCATION (City, town, or county) (State): Flintstone, Maryland.

DATE REC'D BY LOCAL REG.: March 15, 1950

REGISTRAR'S SIGNATURE: Nina L. Bender.

24. FUNERAL DIRECTOR ADDRESS: William H. Kight, Cumberland, Md.

RECEIVED
MAR 16 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

02202

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg, Md.; MARYLAND; LENGTH OF STAY (In this place) 46 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 162 Centre St, Frostburg, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg, Md.; STREET ADDRESS (If rural, give location) 162 Centre St.

3. NAME OF DECEASED (Type or Print): (First) Julia (Middle) Alice (Last) Ansel

4. DATE OF DEATH: (Month) March (Day) 25th, (Year) 19 50

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Apr. 6th, 1866

9. AGE last birthday: 85 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Flintstone, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry Perrin

14. MOTHER'S MAIDEN NAME: Amy Robinette

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. James Ansel, 162 Centre St. Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion due to	at once
420.1 94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H. V. Deming M. D. H. V. Deming M.D. Cumberland Md. March 25-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 3-28-50

NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG. 3-27-50

REGISTRAR'S SIGNATURE: Mrs. Hallie N. Roe

24. FUNERAL DIRECTOR ADDRESS: Jacob Hafer, 23 E. Main St, Frostburg Md.

RECEIVED
MAR 29 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

02203

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural) Westernport; LENGTH OF STAY (In this place) 71 yrs.; MARYLAND; HOSPITAL OR INSTITUTION OR STREET ADDRESS Stoney Run Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural) Westernport; STREET ADDRESS (If rural, give location) Stoney Run Road

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) Aretta (Last) Armold

4. DATE OF DEATH: (Month) March (Day) 1 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: April 21-1878

9. AGE last birthday: 71 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Westernport Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: John Stine

14. MOTHER'S MAIDEN NAME: Ella Mc Dermott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: -----

17. INFORMANT: Percy Miller

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Broncho Pneumonia	about 2 weeks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio-vascular-renal disease	15 yrs
442 / 13(a)	(c) Bronchial asthma	several years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland Md. March 1-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: March 3, 1950

NAME OF CEMETERY OR CREMATORY: Philos Cemetery

LOCATION (City, town, or county) (State): Westernport, Maryland

DATE REC'D BY LOCAL REG.: Mar. 2/50

REGISTRAR'S SIGNATURE: [illegible]

24. FUNERAL DIRECTOR: E. S. Boal

ADDRESS: Westernport, Maryland

VS. A15A

RECEIVED
MAR 8 1950
BUREAU V. S.

Within corporate limits.

02204

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 38 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 7 North Waverly Terrace	STREET ADDRESS (If rural, give location): 7 North Waverly Terrace

3. NAME OF DECEASED (Type or Print)	(First) Charles	(Middle) Francis	(Last) Arnold	4. DATE OF DEATH	(Month) March (Day) 4 (Year) 1950
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: June 26 1886	9. AGE last birthday: 63 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Train Dispatcher	10b. KIND OF BUSINESS OR INDUSTRY: W. Md. R.R.	11. BIRTHPLACE (State or foreign country): Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME: Joseph Arnold	14. MOTHER'S MAIDEN NAME: Barbara Fidler				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 705 10 6045	17. INFORMANT AND ADDRESS: Elizabeth Arnold 7 N. Waverly Terr			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary thrombosis	1944
420.1 Antecedent cause(s)		to
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive arteriosclerotic disease	1950.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Asthma.

19a. DATE OF OPERATION: —	19b. MAJOR FINDINGS OF OPERATION: —	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October, 1944, to March, 1950, that I last saw the deceased alive on 3/4, 1950, and that death occurred at 9 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John K. Rozum M.D.		Cumberland Maryland	3/4/1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Mar. 7, 1950	NAME OF CEMETERY OR CREMATORY: St. Josephs Cemetery	LOCATION (City, town, or county) (State): Texas, Maryland
DATE REC'D BY LOCAL REG.: March 5, 1950	REGISTRAR'S SIGNATURE: Winter R. Frantz M.D.	24. FUNERAL DIRECTOR: William H. Kight, Cumberland, Md.	ADDRESS

156 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 14 1960
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

02205

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland | LENGTH OF STAY (In this place): 18 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 717 Louisana Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 717 Lousiana Ave

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Boyd (Last) Baker, M.D.

4. DATE OF DEATH: (Month) March (Day) 12 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: July 5 1888

9. AGE last birthday: ~~89~~ 61 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Medical Examiner

10b. KIND OF BUSINESS OR INDUSTRY: B & O R R

11. BIRTHPLACE (State or foreign country): Georgetown, S C.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: William Baker

14. MOTHER'S MAIDEN NAME: Louise LeGette

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes | (If yes, give war or dates of service): World War

16. SOCIAL SECURITY NO.: 705-05-2453

17. INFORMANT AND ADDRESS: Mrs Margaret Baker, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: 3 hrs.

Antecedent cause(s)

420.1 940 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: — (CITY OR TOWN): Cumberland (COUNTY): Alleg (STATE): Md

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/11/50, 19....., to 3/12/50, 19....., that I last saw the deceased alive on 3/12/50, 19....., and that death occurred at 6 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Richard J. Williams — ADDRESS: M.D. Cumberland, Md. — DATE SIGNED:

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Mar 15 1950 | NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: March 15, 1950 | REGISTRAR'S SIGNATURE: Walter L. Lantz, M.D. | 24. FUNERAL DIRECTOR: William H. Kight, Cumberland, Md. — ADDRESS:

V2247

RECEIVED
MAR 21 1950
RIVERAIN

Within corporate limits

DR. DYER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02206

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: ALLEGANY; STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MARYLAND; COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND; LENGTH OF STAY (in this place): 4-DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: RT # 4 MEXICO FARMS CUMB. MD.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): Near CUMBERLAND, Rural

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
OSCAR	EARL	BARNEY	MARCH 17 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days / Hours / Min.
MALE	WHITE	WIDOWED	3-3-1894	56 yrs.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farm Owner	Farmer	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ANDREW BARNEY	SARA E. BATIE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
Unknown	218-24-8584	Mrs. J.J. Johnson R.D.4 Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
18l Immediate cause	(a) Cardiac Failure	2 yrs
Antecedent cause(s)		
52b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Ca of bladder	2 yr.
	(c) Uremia	2 mo
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 3-13-50, 19..., to 3-17, 19..., that I last saw the deceased alive on 3-12, 1950, and that death occurred at 10:55 Am., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Chas A Dyer MD 247 Va Ave 3-17-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3-20-1950	Christian Church	Buckvalley, Penna.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 19, 1950	Wirter R. Frantz, M.D.	Charles L. George	Cumberland, Md.

VS. A15

RECEIVED
MAR 23 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH Dr P E Berry

2411 N. Charles Street, Baltimore

02207

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-1

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; LENGTH OF STAY (in this place) 18 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS 428 Hammond St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) 428 Hammond Street

3. NAME OF DECEASED (Type or Print): (First) CECIL (Middle) DELANGUE (Last) BATESON

4. DATE OF DEATH: (Mooth) March (Day) 27 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: June 7, 1894

9. AGE last birthday: 55 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Westernport, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Bateson

14. MOTHER'S MAIDEN NAME: Iona Fazenbaker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service) - - +

16. SOCIAL SECURITY NO.: 705-05-4357

17. INFORMANT AND ADDRESS: Mrs. Cecil D. Bateson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cancer of Lungs — Interval Between Onset and Death: 10 mos

163x

Antecedent cause(s)

47d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 19 49, to March 27, 19 50, that I last saw the deceased alive on Mar 27, 19 50, and that death occurred at 8 10 p. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

P E Berry MD Piedmont WVa 3/29/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Mar 30, 50

NAME OF CEMETERY OR CREMATORY: Philos Cemetery

LOCATION (City, town, or county) (State): Westernport, Md.

DATE REC'D BY LOCAL REG. Mar 31/50

REGISTRAR'S SIGNATURE [illegible] M.D.

24. FUNERAL DIRECTOR: E S Boal

ADDRESS: Westernport, Maryland

2545

RECEIVED
MAR 31 1950
FBI - SPRAU - W. F.

Within corporate limits: DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02208

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND | LENGTH OF STAY (in this place) 10 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA COUNTY GRANT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PETERSBURG,
STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print): (First) JEFF (Middle) (Last) BERGDOLL
4. DATE OF DEATH: (Month) MARCH (Day) 9, (Year) 1950

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: OCTOBER 12 1871-78
9. AGE last birthday: yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMING
10b. KIND OF BUSINESS OR INDUSTRY: farm owner
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GEORGE BERGDOLL
14. MOTHER'S MAIDEN NAME: SUSAN THORNE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL -CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arteriosclerosis with myocardial degeneration

422.1 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Benign hypertrophy Prostate

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-27-, 1950, to 3-9-, 1950, that I last saw the deceased alive on 3-8-, 1950, and that death occurred at 2.35 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Howard R. Tolson M.D. Cumberland Md. 3-9-50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 3/11/50 | NAME OF CEMETERY OR CREMATORY Maple Hill | LOCATION (City, town, or county) Petersburg | (State) W Va

DATE REC'D BY LOCAL REG. March 9, 1950 | REGISTRAR'S SIGNATURE Walter R. Frantz, M.D. | 24. FUNERAL DIRECTOR P C Thrush & Son | ADDRESS Petersburg, W. Va

Per Brown Grant

RECEIVED
MAR 14 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr Reeves 02209

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; MARYLAND; LENGTH OF STAY (in this place) 22 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS 138 Church Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; STREET ADDRESS (If rural, give location) 138 Church Street

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Louise (Last) Bishoff

4. DATE OF DEATH: (Month) March (Day) 7 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Jan 26, 1865

9. AGE last birthday: 85 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Cross, W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joshua W. Kight

14. MOTHER'S MAIDEN NAME: Eliza Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): - - -

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Chester Bishoff

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Myocardial insufficiency	2 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	6 mo.
	(c)	

422.2
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1950, to March 7, 1950, that I last saw the deceased alive on March 7, 1950, and that death occurred at 1:30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Norman Reeves, M.D. Westernport, Md March 8, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: March 9, 1950

NAME OF CEMETERY OR CREMATORY: Meadow Point Cem.

LOCATION (City, town, or county) (State): Keyser, W. Va.

DATE REC'D BY LOCAL REG. 3/9/50

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: E. S. Boal

ADDRESS: "esternport, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 20 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02210

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miller's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) R-2. No 5.

3. NAME OF DECEASED (Type or Print): (First) Sharon (Middle) Lee (Last) Blubaugh

4. DATE OF DEATH: (Month) 3 (Day) 30 (Year) 1950

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: 3-25-1950
9. AGE last birthday: yrs. If under 1 year: Months, Days 5 days, Hours, Min. If under 24 hrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Frostburg Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Joseph A. Blubaugh
14. MOTHER'S MAIDEN NAME: Blanche Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Jos. A. Blubaugh, R-2. No 5 Cumberland Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pneumonia, Bronchial	Few hours.
Antecedent cause(s)	(b) Upper Respiratory Infection.	1½ to 2 days
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Prematurity - 7 months - 2 lbs 4 oz.	

763.5
159

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-25, 1950, to 3-30, 1950, that I last saw the deceased alive on 3-30, 1950, and that death occurred at 1:25 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): John B. Davis, M.D.
ADDRESS: Frostburg, Md
DATE SIGNED: 3/30/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 3-31-1950
NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery
LOCATION (City, town, or county): Eckhart (State) Md

DATE REC'D BY LOCAL REG. 3-31-50
REGISTRAR'S SIGNATURE: Mrs Dawley K. Roe
24. FUNERAL DIRECTOR: Jacob Hafer, ADDRESS: Frostburg, Md.

2-0-2-06-0-34-8-28-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 3 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

02211

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Ella (Middle) C. (Last) Brailer

4. DATE OF DEATH: (Month) March (Day) 13 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: March 9-1889

9. AGE last birthday: 61 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Mt Savage Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George C.Brailer

14. MOTHER'S MAIDEN NAME: Emma Derman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: None

17. INFORMANT: George Brailer Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Uremia due to — 3.1/2days

592 / 131b **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) chronic glomerulonephritis — ?

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland Md. March 14-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Mar.16,1950 | NAME OF CEMETERY OR CREMATORY: St. Patricks Cemetery | LOCATION (City, town, or county) (State): Mt. Savage, Md.

DATE REC'D BY LOCAL REG.: March 15, 1950 | REGISTRAR'S SIGNATURE: Wirtes L. Wantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: William H. Kight, Cumberland, Md.

RECEIVED
MAR 21 1950
BUREAU V

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

02212

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Cumberland; LENGTH OF STAY (In this place) 60 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D.1- Box 252

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Cumberland; STREET ADDRESS (If rural, give location) R.F.D.1- Box 252

3. NAME OF DECEASED (Type or Print): (First) George (Middle) (Last) Brotemarkle

4. DATE OF DEATH: (Month) March (Day) 2 (Year) 1950

5. SEX: male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married

8. DATE OF BIRTH: Feb. 25-1876

9. AGE last birthday: 74 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auditor & bookkeeper

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Bedford Co. Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Milton Brotemarkle

14. MOTHER'S MAIDEN NAME: Mary Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-05-7665

17. INFORMANT: Lillian M. Brotemarkle

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause (a)	Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Coronary sclerosis	?
(c)		

420.1

94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D.	H.V.Deming M.D.	Cumberland Md.	March 2-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	March 4, 1950	Rose Hill Cem	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 3, 1950	Walter K. Hantz, M.D.	William H. Kight	Cumberland, Md.

21099

RECEIVED
MAR 7 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

02213

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 75 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 214 Roberts St Extended

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 214 Roberts St. Extended

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) E. (Last) Brown

4. DATE OF DEATH: (Month) March (Day) 24 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow

8. DATE OF BIRTH: Nov. 23-1854

9. AGE last birthday: 95 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Bolivar Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas E. Brown

14. MOTHER'S MAIDEN NAME: Sarah E. Brandlinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Grace Brant

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
420.1 **Immediate cause**	(a) Coronary occlusion	at once
94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V. Deming M.D. H. V. Deming M.D. Cumberland Md. March 25-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Mar. 28, 1950 | NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: March 27, 1950 | REGISTRAR'S SIGNATURE: Wintes R. Bantz, M.D.

24. FUNERAL DIRECTOR | ADDRESS: William H. Kight, Cumberland, Md.

RECEIVED
APR 4 1950
BUREAU V. S.

Dr McLane
02214

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): 8 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - Frostburg
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) ANNA (Middle) (Last) BUGOSH

4. DATE OF DEATH: (Month) March (Day) 27, (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 8-10-1888

9. AGE last birthday: 61 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hungary

12. CITIZEN OF WHAT COUNTRY? ~~U.S.A.~~

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Paul Bugosh, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.2 **Immediate cause** (a) Chr Myocarditis — 7

Antecedent cause(s)

934 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 18, 1950, to Mar 27, 1950, that I last saw the deceased alive on Mar 26, 1950, and that death occurred at 12:57 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W O McLane MD Frostburg Md 3-28-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 3-29-50 | NAME OF CEMETERY OR CREMATORY: St. Michaels Cemetery | LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 3-29-50 | REGISTRAR'S SIGNATURE: Mrs Nancy V. Roe

24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md. ADDRESS

RECEIVED
APR 3 1950
BUREAU V. S.

02215

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 3days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midland
STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Joseph (Last) Campbell

4. DATE OF DEATH (Month) March (Day) 30 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Dec 23, 1872
9. AGE last birthday 77 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Custodian
10b. KIND OF BUSINESS OR INDUSTRY Public School
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Campbell
14. MOTHER'S MAIDEN NAME Margaret Keating

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ✓ (If yes, give war or dates of service) ✓
16. SOCIAL SECURITY NO. ✓
17. INFORMANT Eileen Campbell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

422.2 Immediate cause (a) Chr Myocarditis ? ?

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 25, 1950, to Mar 30, 1950, that I last saw the deceased alive on Mar 29, 1950, and that death occurred at 5:15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W O McLane MD Frostburg Md 4-1-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF April 3, 1950
NAME OF CEMETERY OR CREMATORY St Patricks Cemetery
LOCATION (City, town, or county) Mt Savage (State) Maryland

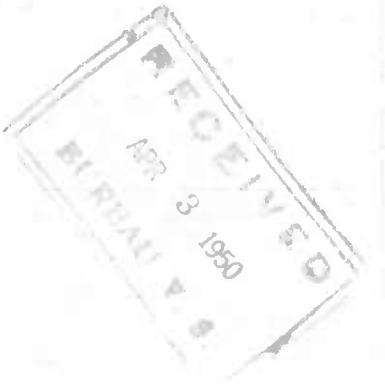
DATE REC'D BY LOCAL REG. 4-1-50
REGISTRAR'S SIGNATURE Mrs. Henry N. Roe
24. FUNERAL DIRECTOR M. Eichhorn
ADDRESS Lonaconing, Maryland

602 91

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15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APR 3 1950

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02216

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 10 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart Mines; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	Barry	Canning	3	22	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widowed	April 14, 1913	36 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework (own)		Eckhart Mines, Md	U.S.

13. FATHER'S NAME: James Barry

14. MOTHER'S MAIDEN NAME: Clara Rose Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no	none	DeSales Barry - Eckhart Mines Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260 — Immediate cause (a) Terminal cardiac failure.

Antecedent cause(s)

61 — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) 1. Nephrosclerosis with renal insufficiency.

(c) 2. Diabetes mellitus.

3. Arteriosclerotic and coronary heart disease. — Interval Between Onset and Death: 1 yr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from March, 1947, to Mar. 22, 1950, that I last saw the deceased alive on Mar. 22, 1950, and that death occurred at 11:20 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. Alfred Vance	M.D.	531 Louisiana Ave., Cumberland, Md.	March 23, 1950

23. BURIAL / CREMATION / REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/25/50	St. Michaels Cemetery	Frostburg, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 24, 1950	Walter R. Frantz, M.D.	Jacob Hafer	Frostburg, Maryland

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BUREAU V. S.

Within corporate limits: Yes

02217

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): ?
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Sylvan Retreat

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 39 Humbird St.

3. NAME OF DECEASED (Type or Print): (First) Clara (Middle) C. (Last) Carlson

4. DATE OF DEATH: (Month) 3/ (Day) 13/ (Year) 19 50

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 7/9/~~56~~ 1874

9. AGE last birthday: 75 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~None~~ Practical Nurse

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Greenfield, Ohio

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Lorenzo D. Johnson

14. MOTHER'S MAIDEN NAME: Mary Layman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.: ~~None~~ 215-12-3117

17. INFORMANT: Clarence Kline 39 Humbird St. (Son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial failure	3 wks
420.1 Antecedent cause(s) 940 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis	2 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 26, 1949, to Mar. 13, 1950, that I last saw the deceased alive on Mar. 12, 1950, and that death occurred at 9:10 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Arthur E. Jones M.D. ADDRESS: 110 S. Centre St. DATE SIGNED: Mar. 15, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 3/16/50 | NAME OF CEMETERY OR CREMATORY: Rose Hill Cem | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: March 15, 1950 | REGISTRAR'S SIGNATURE: Wynter K. Kantz, M.D.

24. FUNERAL DIRECTOR: James F. Scarpelli ADDRESS: Cumberland, Md.

760 86

VS. A15

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MAR 21 1950
BUREAU

Within corporate limits — Yes ☐ No ☐ Cumberland

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02218

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 2 HRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD.
STREET ADDRESS (If rural, give location): 416 PACA STREET

3. NAME OF DECEASED (Type or Print): (First) THOMAS (Middle) E. (Last) CHANEY

4. DATE OF DEATH: (Month) MARCH (Day) 12 (Year) 19 50

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: 3/12/1900

9. AGE last birthday: 50 yrs. If under 1 year: Months. If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mining Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Coal Co.

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: HENRY ELBIN CHANEY

14. MOTHER'S MAIDEN NAME: ALICE MURPHY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: 232-03-1563

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL-CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Myocardial Failure	10 min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Severe Myocardial degen. 433.0	?
	(c) Coronary Artery disease 93e	?
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death	Rt. Bundle Branch Block	?

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/29, 19 49, to 3/12, 19 50, that I last saw the deceased alive on 3/12, 19 50, and that death occurred at 1:40 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Donald DeBrandeburg — ADDRESS: 50 Pershing St. — DATE SIGNED: 3/13/50

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE: 3-14-1950 — NAME OF CEMETERY OR CREMATORY: Clayton Cemetery — LOCATION (City, town, or county) (State): Fairview, W. Va.

DATE RECD BY LOCAL REG.: March 14, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: Charles L. George Cumberland, Md.

1/24 49

RECEIVED
MAR 21 1950
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

02219

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg; STREET ADDRESS (If rural, give location) Park Avenue

3. NAME OF DECEASED (Type or Print): (First) FEDELE (Middle) (Last) COLOSSIMO

4. DATE OF DEATH: (Month) March (Day) 7, (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) widowed

8. DATE OF BIRTH: 8-12-1872

9. AGE last birthday: 77 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10b. KIND OF BUSINESS OR INDUSTRY: Stonemason

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Virgil Colossimo

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Joseph Colossimo, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Strangulated R. Inguinal Hernia — Interval Between Onset and Death: > Days

561.0

Antecedent cause(s)

122a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: Refused Operation

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 1, 1950, to Mar 7, 1950, that I last saw the deceased alive on Mar 6, 1950, and that death occurred at 7:15 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wm Lane MD Frostburg Md 3-7-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 3-9-50

NAME OF CEMETERY OR CREMATORY: St. Michaels Cemetery

LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 3-9-50

REGISTRAR'S SIGNATURE: Dan Haley V. Roe

24. FUNERAL DIRECTOR ADDRESS: J. R. Durst, Frostburg, Md.

30659

RECEIVED
MAR 13 1950
BUREAU U. S.

Within corporate limits

02220

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md ~~15 Weber St.~~ — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 15 Weber St.

3. NAME OF DECEASED (Type or Print): (First) Herman (Middle) Joseph (Last) Curry

4. DATE OF DEATH: (Month) March (Day) 14 (Year) 1950

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 23/1901
9. AGE last birthday: 48 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Kennedy Weg Co.
10b. KIND OF BUSINESS OR INDUSTRY: Warehouse Foreman
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Tarlton Curry
14. MOTHER'S MAIDEN NAME: Hattie Jane De Haven

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-05-5804
17. INFORMANT AND ADDRESS: Orrie J. Curry

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Embolis — 4 days.

Antecedent cause(s) (b) Arteriosclerotic C.V. Disease — Years

433.1 93d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Auricular Fibrillation.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1949 to March, 1950 that I last saw the deceased alive on March 14, 1950, and that death occurred at 12:50 P m., from the causes and on the date stated above.

SIGNATURE: B. M. Schindler — (Degree or title) M.D. — ADDRESS: 41 Greenett, Cumberland Md. — DATE SIGNED: March 16/1950

23. BURIAL CREMATION REMOVAL (Specify): Burial — DATE: March 17, 1950 — NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery — LOCATION (City, town, or county): Cumberland — (State): Md.

DATE REC'D BY LOCAL REG.: March 17, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: John J. Hafer — ADDRESS: Cumberland Md.

316 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 21 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02221

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hosp.	STREET ADDRESS (If rural, give location) 501 N. Centre St.,

3. NAME OF DECEASED (Type or Print)	(First) LESTER	(Middle) ALBERT	(Last) DAVIS	4. DATE OF DEATH	(Month) Mar. 18, (Day) (Year) 1950
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH July 28, 1949	9. AGE last birthday yrs.	If under 1 year Months 7 Days 20 / If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Lester Davis		14. MOTHER'S MAIDEN NAME Hazel Phillips			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Lester Davis 501 N. Centre St., Cumb.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

291X Immediate cause (a) bronchopneumonia — 2 weeks

Antecedent cause(s)

107 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c) hypochromic anemia

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. hypochronic

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/13, 1950, to 3/18, 1950, that I last saw the deceased alive on 3/17, 1950, and that death occurred at 5.50 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Elizabeth Bridge, M.D. 55 Greene St. Cumberland 3/20/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 3/20/50	NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.	LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. March 19, 1950	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.	ADDRESS

2-0-7-28-9-21-3-40-9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M C I VS. A15

RECEIVED
MAR 28 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02222

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Corrigansville, Md.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) U. [illegible] (Middle) Benjamin Franklin (Last) Dawson

4. DATE OF DEATH: (Month) 3 (Day) 16 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced

8. DATE OF BIRTH: May 19 1877

9. AGE last birthday: 72 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saw Repair Man

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isaac Dawson

14. MOTHER'S MAIDEN NAME: Emily Dawson (no relation)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Edgar Dawson, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial failure	2 wks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	4 yrs
	(c)	

420.1
940

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 8, 1949, to Mar. 17, 1950, that I last saw the deceased alive on Mar. 14, 1950, and that death occurred at 11:42 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Arthur F. Jones M.D. — 110 S. Centre St. — Mar. 17 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 3/18/50 | NAME OF CEMETERY OR CREMATORY: Rose Hill Cem | LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Mar 18, 1950 | REGISTRAR'S SIGNATURE: Hunter R. Trump M.D | 24. FUNERAL DIRECTOR: Louis Stein Inc. | ADDRESS: Cumberland Md

33½ 60

RECEIVED
MAR 21 1950
BUREAU V

02223

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hope Route Route 2

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) Hope Road Route 2

3. NAME OF DECEASED (Type or Print) (First) Annie (Middle) (Last) Leal

4. DATE OF DEATH (Month) 3 (Day) 15 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 12-5-1880
9. AGE last birthday 69 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Mt. Savage Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Manuel Beal
14. MOTHER'S MAIDEN NAME Beal

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS James Deal Hope Road Frostburg Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chr Myocarditis	several years
Antecedent cause(s)	(b) Bronchial Asthma	" "
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

241
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 15, 1950, to Mar 15, 1950, that I last saw the deceased alive on Mar 15, 1950, and that death occurred at 5:30P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W O McLane MD
ADDRESS Frostburg Md
DATE SIGNED 3-17-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 3-18-1950
NAME OF CEMETERY OR CREMATORY Porter's Cemetery
LOCATION (City, town, or county) Parkhurst (State) Md

DATE REC'D BY LOCAL REG. 3-18-50
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hafer, Frostburg Md.
ADDRESS

M

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 21 1950
[illegible] BRAIL V. S.

Within corporate limits

02224

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Allegany Grove near Cumberland
STREET ADDRESS (If rural, give location): RD 1 Cumberland.

3. NAME OF DECEASED (Type or Print) (First): Margaret (Middle): Susan (Last): Deal
4. DATE OF DEATH (Month): Mar (Day): 1 (Year): 1950
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 4, 1875
9. AGE last birthday: 74 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Somerset Pa
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Solomon Lenhart
14. MOTHER'S MAIDEN NAME: Mary Shaulis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Harry L. Deal - Rt 1 Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

334 Immediate cause (a) Cerebral apoplexy — 11 days

Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Hypertention — 10 yrs ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-18-50, 19..., to 3-1-, 1950, that I last saw the deceased alive on 3-1-, 1950, and that death occurred at 8:56 P m., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title): M.D. ADDRESS: Cumberland Md DATE SIGNED: 3-3-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Mar 4, 1950 — NAME OF CEMETERY OR CREMATORY: Union Cemetery — LOCATION (City, town, or county) (State): Meyersdale Pa.
DATE REC'D BY LOCAL REG.: March 4, 1950 — REGISTRAR'S SIGNATURE: Winter R. Tank, M.D.
24. FUNERAL DIRECTOR: John J. Hafer — ADDRESS: Cumberland Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 7 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02225

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland.; MARYLAND; LENGTH OF STAY (in this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS Algonquin Hotel

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland, COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural give location) Algonquin Hotel

3. NAME OF DECEASED (Type or Print): (First) Florence (Middle) Elizabeth (Last) Deetz

4. DATE OF DEATH: (Month) March (Day) 10 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Feb. 9 1868

9. AGE last birthday: 82 yrs.; If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None.

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Hampshire Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Solomon J Pugh

14. MOTHER'S MAIDEN NAME: Margaret McDonald

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No; (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Wm R. Deetz, Cumb'd Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis.	45 Min'
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension, Coronary Heart Desease	Unk.
	(c) Advanced age, Senility.	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒ NO

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: None

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 20 1949, to March 10 1950, that I last saw the deceased alive on 3/10/50, 19....., and that death occurred at 2.45 A.M., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title) M.D. ADDRESS 140 Bedford St DATE SIGNED 3/10/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial; DATE: Mar 13'50; NAME OF CEMETERY OR CREMATORY: Rose Hill Cem; LOCATION (City, town, or county): Cumberland; (State): Md

DATE REC'D BY LOCAL REG.: March 13 1950; REGISTRAR'S SIGNATURE: Winter R. Deetz M.D.; FUNERAL DIRECTOR: Louis Stein Inc; ADDRESS: "

RECEIVED
MAR 21 1950
BUREAU V. S.

Within corporate limits

02226

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 79 Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 215 Charles Street	STREET ADDRESS (If rural, give location): 215 Charles Street

3. NAME OF DECEASED (Type or Print)	(First) William	(Middle) Howard	(Last) Deetz	4. DATE OF DEATH	(Month) March (Day) 22 (Year) 1950
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Mar 22 1871	9. AGE last birthday: 79 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plastering Houses	10b. KIND OF BUSINESS OR INDUSTRY: Plaster	11. BIRTHPLACE (State or foreign country): Cumberland, Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: William Deetz	14. MOTHER'S MAIDEN NAME: Mary E. Zimmerla				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 219-03-0806	17. INFORMANT AND ADDRESS: Miss Olga Deetz, Cumberland, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.0	Immediate cause	(a) acute coronary occlusion	1/2 hour
93d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerotic heart disease	1 year
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-4-, 1949, to 3-22-, 1950, that I last saw the deceased alive on 3-17-, 1950, and that death occurred at 8 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
[signature]	MD	57 Greene St.	3-23-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Mar 25 1950	NAME OF CEMETERY OR CREMATORY: Hill Crest Burial Park	LOCATION (City, town, or county) (State): Cumberland, Md.
DATE REC'D BY LOCAL REG.: March 24, 1950	REGISTRAR'S SIGNATURE: Winter R. Trainty M.D.	24. FUNERAL DIRECTOR: William H. Kight, Cumberland, Md.	ADDRESS

346V9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
MAR 28 1950
ST. REPAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02227

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STATE: MARYLAND
LENGTH OF STAY (in this place): 35 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 112 S. Center St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland, Md.
STREET ADDRESS (If rural, give location): 112 S. Center St.

3. NAME OF DECEASED (Type or Print): (First) Florence (Middle) Adella (Last) Deffenbaugh

4. DATE OF DEATH: (Month) March (Day) 23 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: September 17, 1875

9. AGE last birthday: 74 yrs. If under 1 year: Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Mt. Savage, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel L. Piper

14. MOTHER'S MAIDEN NAME: Caroline Sills

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Miss Olive Deffenbaugh, 112 S. Center St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442 **Immediate cause** (a) Uremia — Interval between onset and death: 36 hours

Antecedent cause(s)

131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Nephrosclerosis — ?

(c) Hypertensive Cardiovascular disease — 10 yr

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Multiple Cerebral Thrombose disease — 5 yr

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, office bldg., etc.): None (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): None m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? None

22. I hereby certify that I attended the deceased from Nov 18, 1949, to March 23, 1950, that I last saw the deceased alive on March 23, 1950, and that death occurred at 6 30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Estelle G. Weisman M.D. ADDRESS: 122 Bedford St Cumberland, Md DATE SIGNED: 3/25/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: March 25, 1950
NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: March 25, 1950
REGISTRAR'S SIGNATURE: Winter K. Frantz, M.D.

24. FUNERAL DIRECTOR: John J. Hafer, ADDRESS: Cumberland, Md.

RECEIVED
MAR 28 1950
BUREAU T. S.

Within corporate limits

Van Orner

MARYLAND STATE DEPARTMENT OF HEALTH

02228

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

I

VS. A15

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hosp.	STREET ADDRESS (If rural, give location) 164 N. Centre St.,

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Louis	A.	DelaGrange	March	28,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months.	Days	If under 24 hrs. Hours	Min.
Male	White	Widowed	July 29,1886	63 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired-Salesman-Checker	Kelly Tire Co	Auburn, Indiana	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles F. DelaGrange	Eugenia Morel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	214-07-0836	Vincent DelaGrange 815 Yale St., Cumb.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Generalized carcinomatosis	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma prostate	Approx. 3 years.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Mar. 1, 1950, to Mar. 28, 1950, that I last saw the deceased alive on Mar. 25, 1950, and that death occurred at 4:40 m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Walter Van Orner		531 Louisiana Ave. Cumberland, Maryland	

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 1,1950	N. Springfield Presbyterian	Akron, Ohio

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 30,1950	Walter R. Frantz, M.D.	H. Wayne George	Cumberland, Md.

328 2 V

RECEIVED
APR 4 1950
BUREAU V. S.

DR. W. F. WILLIAMS

Within corporate limits

02229

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 8 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FLINTSTONE
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) ROUTE #1

3. NAME OF DECEASED (Type or Print) (First) HARRY (Middle) (Last) DICKEN			4. DATE OF DEATH (Month) MARCH (Day) 10 (Year) 1950		
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH FEB.5,1879	9. AGE last birthday 71 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE Retired	10b. KIND OF BUSINESS OR INDUSTRY Farm owner		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM DICKEN			14. MOTHER'S MAIDEN NAME REBECCA ROBINETTE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)		16. SOCIAL SECURITY No. None	17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Nephritis c̄ Hypertension

260 Antecedent cause(s)

61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis,

(c) Diabetes Mellitus

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-2-, 1950, to 3-10-, 1950, that I last saw the deceased alive on 3-10-, 1950, and that death occurred at 3:10 Am., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Wm. F. Williams	Cumberland	3/10/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE March 13,1950	NAME OF CEMETERY OR CREMATORY Prosperity Christian Cemetery	LOCATION (City, town, or county) (State) R.D.1, Flintstone, Md.
DATE REC'D BY LOCAL REG. March 12, 1950	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR R. K. Shoemaker	ADDRESS Everett, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS.A15

000 VV

RECEIVED
MAR 21 1950
BUREAU V. S.

Outside of City limits

02230

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland, Rural — LENGTH OF STAY (in this place): 40 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Rt 3 Naves Crossroads

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Near Cumberland, Rural
STREET ADDRESS (If rural, give location): Rt 3 Naves Crossroads.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Annie	Cromer	Edwards	Mar	24	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	Black	Married	Mar 1889	61 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework - Retired	Private Home	Newberry S. Carolina	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Adam Cromer	Fannie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
No	None	Walter Edwards, Rt 3 Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arteriosclerotic heart disease — 1 year

430.0 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Feb 16, 1950, to Mar 24, 1950, that I last saw the deceased alive on Mar 9, 1950, and that death occurred at 3:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
R.N. Trovaski, M.D.	Cumberland, Maryland	3/27/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Mar 27 1950	Sunnyside Cemetery	Cumberland	Md

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 27, 1950	Hunter R. Frantz, M.D.	John J. Hafer	Cumberland Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

02231

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1325 Virginia Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 1325 Va. Avenue

3. NAME OF DECEASED (Type or Print): (First) Susan (Middle) "Crabtree" (Last) Edwards
4. DATE OF DEATH: (Month) March (Day) 29 (Year) 1950

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept 27, 1879
9. AGE last birthday: 70 yrs. | If under 1 year: Months. | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Old town, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Crabtree
14. MOTHER'S MAIDEN NAME: Lydia Moreland.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Josephine Emerick RFD#4 Cumb.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 8 Hrs.

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cardiovascular Renal Dis.

(c) Diabetes Mellitus

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

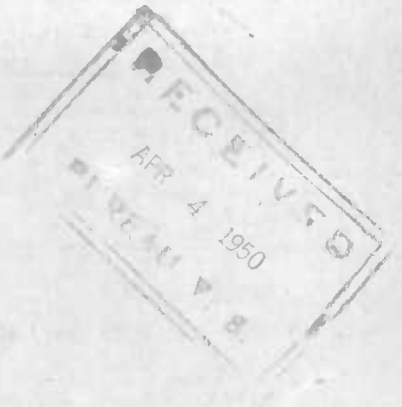
22. I hereby certify that I attended the deceased from 7-1-, 1949, to 3-29-, 1950, that I last saw the deceased alive on 3-27-, 1950, and that death occurred at 4:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
W. K. Williams M.D. Cumberland 3/31/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: April 1, 1950 | NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park | LOCATION (City, town, or county) (State): Cumberland, Md

DATE REC'D BY LOCAL REG.: March 31, 1950 | REGISTRAR'S SIGNATURE: Walter R. Hartz, M.D.

24. FUNERAL DIRECTOR | ADDRESS: John J. Hafer, Cumberland, Md.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APR 4 1950

Within corporate limits

Dr. Murray

02232

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 25 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 201 Thomas St.

3. NAME OF DECEASED (Type or Print): (First) Wm (Middle) McKinley (Last) Elfritz

4. DATE OF DEATH: (Month) Mar (Day) 27 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept 6, 1901

9. AGE last birthday: 48 yrs. If under 1 year: Months. If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipefitter Helper

10b. KIND OF BUSINESS OR INDUSTRY: B & O. Railroad

11. BIRTHPLACE (State or foreign country): Elkgarden W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: Fred W. Elfritz

14. MOTHER'S MAIDEN NAME: Maggie Reed

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If year, give war or dates of service): 1920 to 22

16. SOCIAL SECURITY NO.: 213-12-9680

17. INFORMANT AND ADDRESS: Arthur Elfritz, Barrellsville Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Shock following Perforation of abdomen	1 hour
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cirrhosis of Liver	2 years
	(c) with ascites	1 year

581.0

124 lb

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: March 27, 50

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1948, 19..., to March 27, 1950, that I last saw the deceased alive on March 27, 1950, and that death occurred at 2 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): H. Alan G. Murray MD — ADDRESS: Cumberland Md — DATE SIGNED: March 30, 50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Mar 30, 1950 — NAME OF CEMETERY OR CREMATORY: Cooks Cemetery — LOCATION (City, town, or county) (State): Near Wellersburg Pa.

DATE REC'D BY LOCAL REG.: March 30, 1950 — REGISTRAR'S SIGNATURE: Winter K. Kantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: John J. Hofer Cumberland Md.

24847

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APR 4 1950
BUREAU V. S.

Outside of City limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02233

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Vale; LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS R. D. #1 La Vale

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Vale
STREET ADDRESS (If rural, give location) R. D. #1 La Vale

3. NAME OF DECEASED (Type or Print): (First) HENRY; (Middle) ANDREW; (Last) EVERLINE
4. DATE OF DEATH: (Month) March; (Day) 9; (Year) 1950

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Apr. 6, 1870
9. AGE last birthday: 79 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Bldg. Contractor
11. BIRTHPLACE (State or foreign country): Lonaconing, Md.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Daniel Everline
14. MOTHER'S MAIDEN NAME: Dora Milford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Mrs. Ida B. Everline La Vale, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial Degeneration — Interval Between Onset and Death: 1 yr.

443 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — 1 yr.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/15, 1949, to 3/9, 1950, that I last saw the deceased alive on 3/8, 1950, and that death occurred at 7:30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George M. Simons M.D. 125 Union St Cumberland Md 3/10/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 3/12/50
NAME OF CEMETERY OR CREMATORY: Rose Hill Mausoleum
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: March 10, 1950
REGISTRAR'S SIGNATURE: Vernes R. Frantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George
ADDRESS: Cumberland, Md.

15679

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MAR 14 1950
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

02234

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Sarah	Elizabeth	Fazenbaker	March	31	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Married	May 4, 1870	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work	Own Home	Maryland	U.S.A.

13. FATHER'S NAME: David Broadwater

14. MOTHER'S MAIDEN NAME: Lizie Colmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Clarance Fazenbaker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hypertension case - Arterio sclerotic Cardio-Vascular - renal disease & Auricular &	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Ventricular arrhythmia and uremia.	10 yrs.
	(c)	

442 X
131 a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on 3/31, 19 50, and that death occurred at ....m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Paul Eugene Frye, M.D		Lonaconing Md.	4/5/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	April 3, 1950	Allegany Cemetery	Frostburg	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4-3-50	Jeanette M Boal	M. Eichhorn	Lonaconing, Md.

RECEIVED
APR 17 1950
BUREAU T. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02235

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) 21 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Lagonda St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) Lagonda St

3. NAME OF DECEASED (Type or Print): (First) Margaret (Middle) E. (Last) Feeney

4. DATE OF DEATH: (Month) March (Day) 10 (Year) 19 1950

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single | 8. DATE OF BIRTH: January 1, 1871 | 9. AGE last birthday: 79 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper | 10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Hutton Md. | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter Feeney

14. MOTHER'S MAIDEN NAME: Margaret Flaherty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Peter Feeney Lagonda St

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Generalized Arteriosclerosis — Interval Between Onset and Death: 5 yrs

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

450.0
97

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19 45, to March 10 1950, that I last saw the deceased alive on ....., 19 49, and that death occurred at 9:30 A.m., from the causes and on the date stated above.

SIGNATURE J. Johnson (Degree or title) M.D. | ADDRESS Cumberland Md | DATE SIGNED 3-11-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE 3/13/50 | NAME OF CEMETERY OR CREMATORY: St Peter's Cem | LOCATION (City, town, or county) (State): Oakland, Md.

DATE RECD BY LOCAL REG. March 12, 1950 | REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR | ADDRESS: James F. Scarpelli Cumberland, Md.

VS/A15

5208C

RECEIVED

Within corporate limits

DR. W.F.WMS.

02236

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: MARYLAND COUNTY: GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD. LENGTH OF STAY (in this place): 18 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: FRIENDSVILLE
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.	STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print) (First) EDITH (Middle) (Last) FRANTZ			4. DATE OF DEATH (Month) March (Day) 3 (Year) 1950	
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH: SEPT. ? 1879	9. AGE last birthday: 70 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): MARYLAND	12. CITIZEN OF WHAT COUNTRY: USA.	
13. FATHER'S NAME: TAYLOR FRIEND		14. MOTHER'S MAIDEN NAME: ELLEN FEATHERS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

442 Immediate cause (a) Chronic Hypertensive Heart

Antecedent cause(s)

131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Disease c̄ Chronic Nephritis

(c) Myocardial Degeneration

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 13, 1950, to 3-3-1950, that I last saw the deceased alive on 3-3-1950, and that death occurred at 10:00 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W.F. Williams	M.D.	Cumberland	3-3-50.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	March 5, 1950	Blooming Rose Cemetery	Near Friendsville, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 5, 1950	Winter R. Frantz. M.D.	W.H. Rodahaver	Markleysburg, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 7 1950
BUREAU V. S.

Within corporate limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02237

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND | LENGTH OF STAY (In this place) 33 YEARS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 116 Bedford St.

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE MARYLAND COUNTY ALLEG
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural give location) 116 BEDFORD ST

3. NAME OF DECEASED (Type or Print) (First) MARY (Middle) ISABELLE (Last) FRANTZ
4. DATE OF DEATH (Month) MARCH (Day) 22 (Year) 1950

5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED | 8. DATE OF BIRTH MARCH 2, 1885 | 9. AGE last birthday 65 yrs. | If under 1 year Months Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | 10b. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (State or foreign country) VIRGINIA | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME THOMAS ODEN | 14. MOTHER'S MAIDEN NAME ANNA REEVES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT HUSBAND: DR. WINTER R. FRANTZ

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

153 **Immediate cause** (a) CARCINOMA OF ASCENDING COLON — 4 YEARS

462 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JAN. 3, 1950, to MARCH 22, 1950, that I last saw the deceased alive on MARCH 22, 1950, and that death occurred at 10:20 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Ralph W. Baccio M.D 62 GREENE ST. CUMBERLAND MD 3-22-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF Mar. 24, '50 | NAME OF CEMETERY OR CREMATORY Hillcrest Cem. | LOCATION (City, town, or county) Cumberland | (State) Md

DATE REC'D BY LOCAL REG. March 24, 1950 | REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. | 24. FUNERAL DIRECTOR Lomas Stein, Inc. | ADDRESS Cumberland Md.

VS. A15

RECEIVED
MAR 29 1950
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

02238

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (In this place): 12 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 Beall St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 15 Beall St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Joseph	Micheal	Freeland	March	27	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	white	married	May 6-1911	38 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Service Mgr.	P.Edison Co.	Cumberland Md.	U.S.A.

13. FATHER'S NAME: Charles Freeland

14. MOTHER'S MAIDEN NAME: Elizabeth Lydinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	214-10-5554	wife

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
420.1 **Immediate cause**	(a) Coronary occlusion	at once
94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Dey) (Yeer) (Hour) OF INJURY m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☐, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V.Deming M.D.	Cumberland Md.	March 28-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3-29-50	St. Michaels Cemetery	Frostburg, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3-29-50	Mrs Hazel N. Roe	J. R. Durst, Frostburg, Md.	

15699

RECEIVED
APR 3 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

02239

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 14 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ~~Alberton~~ Accident (rural)
STREET ADDRESS (If rural, give location): R.F.D.#1 Lonaconing Md.

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Britton (Last) Garlitz

4. DATE OF DEATH: (Month) March (Day) 15 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: Nov. 21-1889

9. AGE last birthday: 60 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith

10b. KIND OF BUSINESS OR INDUSTRY: Jenkins Coal Co.

11. BIRTHPLACE (State or foreign country): Accident Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Patrick Garlitz

14. MOTHER'S MAIDEN NAME: Mary A. Mayhew

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 213-18-2712

17. INFORMANT: Roy Garlitz (Son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Intra-abdominal hemorrhage due to a	16 Hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) ruptured abdominal aorta from an	
	(c) arteriosclerotic aneurysm.	

451 × 96

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland Md. March 15-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: MARCH 18, 1950 — NAME OF CEMETERY OR CREMATORY: VAUCLUSE CEMETERY — LOCATION (City, town, or county) (State): ACCIDENT, GARRETT MD

DATE REC'D BY LOCAL REG.: March 15, 1950 — REGISTRAR'S SIGNATURE: Walter K. Hauty, M.D. — **24. FUNERAL DIRECTOR** ADDRESS: Allen Winebrenner GRANTSVILLE, MD

302 V2

RECEIVED
MAR 21 1950
BUREAU V. S.

Within corporate limits

02240

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 30 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 122 Monroe St

3. NAME OF DECEASED (Type or Print): (First) Ella (Middle) (Last) Goodyear

4. DATE OF DEATH: (Month) March (Day) 10 (Year) 19 50

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: July 18-1890

9. AGE last birthday: 59 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Duckworth

14. MOTHER'S MAIDEN NAME: Frances Duckworth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Frank W. Goodyear, Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Intracranial hemorrhage due to a — 31 hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
900.0
186a
(b) basal fracture of the skull.
(c) Fell backward down cellar stairs, at home.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: home
(CITY OR TOWN): Cumberland (COUNTY): Allegany (STATE): Md.
TIME (Month) (Day) (Year) (Hour) OF INJURY: March 9/50 5.15 p. m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? Asending cellar stairs fell backward, hit head on concrete floor.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) — **ADDRESS** — **DATE SIGNED**

H.V. Deming M.D. H.V. Deming M.D. Cumberland Md. March 11-1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: March 14, 1950
NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
LOCATION (City, town, or county) (State): Cumberland, Md

DATE REC'D BY LOCAL REG.: March 14, 1950
REGISTRAR'S SIGNATURE: Winter R. Mantz, M.D.
24. FUNERAL DIRECTOR — **ADDRESS**: John J. Hoffe, Cumberland, Md.

RECEIVED
MAR 21 1950

MARYLAND STATE DEPARTMENT OF HEALTH

02241

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): 1 Day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) George (Middle) William (Last) Grim

4. DATE OF DEATH: (Month) 3 (Day) 18 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 3-10-1880

9. AGE last birthday: 70 yrs. If under 1 year: Months. If under 24 hrs.: Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (State or foreign country): Lead Mine W. Va.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Isaac W. Grim

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY No.: 214-20-2289

17. INFORMANT AND ADDRESS: Mr. George Hice, Curtain W. Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Influenzal Pneumonitis	48 hrs.
Antecedent cause(s)	(b) Anthracosis	yrs.??
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Chronic Myocarditis	yrs.??

480
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: NONE

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1950, to 3/15 ....., 1950, that I last saw the deceased alive on 10:00 P.M. 3/19/50, 1950, and that death occurred at 12:25 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Wm. Rothstein M.D. ADDRESS: 48 Broadway, Frostburg Md. DATE SIGNED: 3/20/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 3-21-1950 — NAME OF CEMETERY OR CREMATORY: Temple Cemetery — LOCATION (City, town, or county): Wellersburg, (State): Pa.

DATE REC'D BY LOCAL REG. 3-21-50 — REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR: Jacob Hafer, Frostburg, Md. ADDRESS:

Dr. Rothstein

988V9

RECEIVED
MAR 24 1950
BUREAU V. M.

Within corporate limits Yes

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02242

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 30 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 518 Fecting Ave.	STREET ADDRESS (If rural, give location) 518 Fecting Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John	Harper	Hafer	March	17	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. Days.	If under 24 hrs.: Hours. Min.
Male	White	Married	Oct 15 1893	56 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rubber Worker	Kelly Tire Co.	Bedford Valley Pa	U.S

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Andrew S. Hafer	Emma Nave

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	214-05-5913	Mrs John Hafer, 518 Fecting Ave Cbld

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	½ hr.
420.1 Antecedent cause(s)		
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Sept, 19 48, to March 17 1950, that I last saw the deceased alive on March 17, 1950, and that death occurred at 2:20A m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
George M Strom M.D.	128 Union St Cumberland Md	3/18/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Mar 19, 1950	P.O.S. of A. Cemetery	Centerville Pa.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 19, 1950	Wenter K. Mantz, M.D.	John J. Hafer	Cumberland Md.

988-2V

RECEIVED
MAR 28 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02243

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 40 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 637 N. Mechanic St

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 637 N Mechanic St.

3. NAME OF DECEASED (Type or Print): (First) James (Middle) K. (Last) Harman

4. DATE OF DEATH: (Month) Mar (Day) 14 (Year) 1950

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug 14 1880
9. AGE last birthday: 69 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe fitter (retired)
10b. KIND OF BUSINESS OR INDUSTRY: Railway Shops
11. BIRTHPLACE (State or foreign country): Carneyville W. Va.
12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Jacob H Harman
14. MOTHER'S MAIDEN NAME: Anna Kidwiler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Ret. (If year, give war or dates of service):
16. SOCIAL SECURITY NO.: 705-05-4532
17. INFORMANT AND ADDRESS: Mrs Kathryn Chenowith, Cumbd

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Coronary Thrombosis — Interval Between Onset and Death: 1/2 hr.

420.1 Antecedent cause(s)

940a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): Coronary Artery Disease — 15 yrs.

(c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1950, to Mar 14, 1950, that I last saw the deceased alive on Mar 13, 1950, and that death occurred at 1.25 P m., from the causes and on the date stated above.

SIGNATURE: John A Topper MD (Degree or title) — ADDRESS: Frostburg Md — DATE SIGNED: 3/17/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Mar 17 50 — NAME OF CEMETERY OR CREMATORY: Green Hill Cem — LOCATION (City, town, or county) (State): Martinsburg W. Va

DATE REC'D BY LOCAL REG.: March 17 1950 — REGISTRAR'S SIGNATURE: Hunter A Trout Mgr — 24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland

348.47

RECEIVED
MAR 21 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

02244

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Broadway

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) Broadway

3. NAME OF DECEASED (Type or Print): (First) MAUDE (Middle) ELSIE (Last) HARVEY

4. DATE OF DEATH: (Month) March (Day) 6, (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: 4-24-1881

9. AGE last birthday: 68 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Piedmont, W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alfred Zimmerman

14. MOTHER'S MAIDEN NAME: Margaret E. Clague

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Robert Harvey, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Post Hemiplegic Syndrome — Interval Between Onset and Death: 7 yrs

3348 Antecedent cause(s)

832 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — 7 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from [illegible], 1943, to 3-6, 1950, that I last saw the deceased alive on 3-6, 1950, and that death occurred at 11:45 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wm McLane MD Frostburg Md 3-7-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 3-9-50
NAME OF CEMETERY OR CREMATORY: Philos Cemetery
LOCATION (City, town, or county) (State): Westernport, Md.

DATE REC'D BY LOCAL REG. 3-9-50
REGISTRAR'S SIGNATURE: Mrs. Nancy K. Roe

24. FUNERAL DIRECTOR: J. R. Durst, ADDRESS: Frostburg, Md.

VS. A15

RECEIVED
MAR 13 1950
U. S. PATENT OFFICE

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02245

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 65 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 416 Springdale St

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 416 Springdale St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Charles A. Helgath
4. DATE OF DEATH (Month) (Day) (Year): 3/30/50 19

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 5/28/1884
9. AGE last birthday: 65 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Boilermaker Helper
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Cumberland Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles S. Helgath
14. MOTHER'S MAIDEN NAME: Marie Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If year, give war or dates of service): War I
16. SOCIAL SECURITY NO.: 705-09-9810
17. INFORMANT AND ADDRESS: Juanita Helgath 416 Springdale St

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

177 X

Immediate cause (a) Carcinoma of Prostate — 2 yrs

Antecedent cause(s)

51 b

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —
(CITY OR TOWN) (COUNTY) (STATE): Cumberland Alley Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 3/16/48, 19....., to 3/30/50, 19....., that I last saw the deceased alive on 3/30/50, 19..... and that death occurred at 5:20 P. m., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title) MD, ADDRESS: Cumberland, Md — DATE SIGNED: 3/31/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 4/4/50 — NAME OF CEMETERY OR CREMATORY: Arlington National Cem. — LOCATION (City, town, or county) (State): Arlington Va.

DATE REC'D BY LOCAL REG.: March 31, 1950 — REGISTRAR'S SIGNATURE: Winter R. Hantz, M.D.
24. FUNERAL DIRECTOR: James F. Scarpelli — ADDRESS: Cumberland, Md.

30147

RECEIVED
APR 4 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

02246

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (In this place): 6 Mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 226 Arch St.

3. NAME OF DECEASED (Type or Print): (First) Roberta (Middle) C (Last) High

4. DATE OF DEATH: (Month) March (Day) 13 (Year) 19 50

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow

8. DATE OF BIRTH: Jan. 10-1875

9. AGE last birthday: 75 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hancock Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sylvester Pitman

14. MOTHER'S MAIDEN NAME: Mary C. Shives

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs.H.L.Hiner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331x **Immediate cause** (a) Cerebral hemorrhage (apoplexy) — Interval between onset and death: 3 hrs.

83a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: naturol causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V.Deming M.D. — ADDRESS: H. V. Deming M.D. Cumberland Md. — DATE SIGNED: March 13-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 3/17/50 — NAME OF CEMETERY OR CREMATORY: Cedar Hill — LOCATION (City, town, or county) (State): Washington D. C.

DATE RECD BY LOCAL REG.: March 15, 1950 — REGISTRAR'S SIGNATURE: Winter R. Tantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: Charles L. George Cumberland, Md.

VS. A15A

RECEIVED
MAR 21 1950

02247

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH- COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Grahamtown — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Frostburg, Md.	STREET ADDRESS (If rural, give location): Grahamtown

3. NAME OF DECEASED (Type or Print)	(First) SUZANNA	(Middle) (DEAL)	(Last) HUFF	4. DATE OF DEATH	(Month) March (Day) 31, (Year) 1950
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: 4-4-1869	9. AGE last birthday: 80 yrs.	If under 1 year: Months. Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife	10b. KIND OF BUSINESS OR INDUSTRY: home	11. BIRTHPLACE (State or foreign country): Meyersdale, Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: Jacob Deal		14. MOTHER'S MAIDEN NAME: Mary M. Tressler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS: Ralph Huff			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arteriosclerotic Heart Disease — Years

420.0 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Essential Hypertension — Years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. NONE

19a. DATE OF OPERATION: NONE	19b. MAJOR FINDINGS OF OPERATION: ✓	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify) NONE	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) NONE m.	INJURY OCCURRED While at Work ☐ Not While At work ☐ ✓	HOW DID INJURY OCCUR? ✓

22. I hereby certify that I attended the deceased from DECEMBER, 1949, to MARCH 31, 1950, that I last saw the deceased alive on MARCH 31, 1950, and that death occurred at 11:15 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Martin M. Rothstein M.D.		48 Broadway Frostburg, Md.	3/31/50

23. BURIAL, CREMATION REMOVAL, (Specify) Burial	DATE 4-3-50	NAME OF CEMETERY OR CREMATORY Allegany Cemetery	LOCATION (City, town, or county) Frostburg, Md. (State)
DATE REC'D BY LOCAL REG. 4-3-50	REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe	24. FUNERAL DIRECTOR J. R. Durst, Frostburg, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
APR 10 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02248

CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cresaptown — LENGTH OF STAY (in this place): 68 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cresaptown
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Brace (Middle) B (Last) Hutson

4. DATE OF DEATH: (Month) March (Day) 13 (Year) 1950

5. SEX: Male — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married — 8. DATE OF BIRTH: Feb 7 1882 — 9. AGE last birthday: 68 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith — 10b. KIND OF BUSINESS OR INDUSTRY: Self — 11. BIRTHPLACE (State or foreign country): Cresaptown, Maryland — 12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John B. Hutson — 14. MOTHER'S MAIDEN NAME: Hannah Vanmeter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT AND ADDRESS: Mrs. Brace Hutson, Cresaptown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocarditis — 2 years

422.2 Antecedent cause(s)

93a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1948 to 3-13 1950 that I last saw the deceased alive on 3-11, 1950 and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) James T. Johnson J. M. D. — ADDRESS Cumberland Md — DATE SIGNED 3-14-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Mar. 16, 1950 — NAME OF CEMETERY OR CREMATORY: Hutson Cemetery — LOCATION (City, town, or county) (State): Rawlings, Md.

DATE REC'D BY LOCAL REG. 3/15/50 — REGISTRAR'S SIGNATURE M. H. Vanmeter — 24. FUNERAL DIRECTOR ADDRESS: William H. Kight, Cumberland, Md.

302 85

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 17 1950
BUREAU V. S.

Within corporate limits

02249

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 30 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 247 N. Center St	STREET ADDRESS (If rural, give location) 247 N. Center St.

3. NAME OF DECEASED (Type or Print)	(First) Lawrence	(Middle) Willard	(Last) Iser	4. DATE OF DEATH	(Month) March	(Day) 6	(Year) 1950
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 13, 1916	9. AGE last birthday 33 yrs.	If under 1 year Months. Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Celanese employee	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ridgeley, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles T. Iser			14. MOTHER'S MAIDEN NAME Bertha H. Holt				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS Bertha H. Holt Iser 247 N. Center St.				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Bronchiectasis — 5 years

526 Antecedent cause(s)

106b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-12, 1949, to 3-6, 1950, that I last saw the deceased alive on 3-5, 1950, and that death occurred at 6:00 p.m., from the causes and on the date stated above. 3-8-50

SIGNATURE R. W. Ballin (Degree or title) M.D. ADDRESS 62 Greene St. Cumberland Md DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE March 9, 1950	NAME OF CEMETERY OR CREMATORY Zion Memorial Park	LOCATION (City, town, or county) Cumberland (State) Md
DATE REC'D BY LOCAL REG. March 8, 1950	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR John J. Hofer, Cumberland, Md.	ADDRESS

98816

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 14 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr P R Wilson 02250

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Barton — LENGTH OF STAY (in this place): 6 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Barton
HOSPITAL OR INSTITUTION OR STREET ADDRESS: High Street	STREET ADDRESS (If rural, give location): High Street

3. NAME OF DECEASED (Type or Print)	(First) STANLEY	(Middle) HAMILTON	(Last) JEWELL	4. DATE OF DEATH (Month) March (Day) 22 (Year) 1950
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Dec 11, 1881	9. AGE last birthday: 68 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister	10b. KIND OF BUSINESS OR INDUSTRY: Church	11. BIRTHPLACE (State or foreign country): Tennesee	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Anson Jewell		14. MOTHER'S MAIDEN NAME: Sarah Hamilton		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT AND ADDRESS: Mrs Stanley H Jewell		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Embolus	20 Minutes
260 Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis and Chronic Nephritis	1 Year
61	(c) Diabetes Mellitus	15 Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify): None	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 15, 1949, to Mar 22, 1950, that I last saw the deceased alive on Mar. 20, 1950, and that death occurred at 8:30 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Paul R. Wilson	M.D.	Piedmont, W. Va.	Mar 24, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: March 26, 50	NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery	LOCATION (City, town, or county) (State): ~~XXXXX~~ Moscow, Maryland
DATE REC'D BY LOCAL REG.: Mar. 26/50	REGISTRAR'S SIGNATURE: [signature] M.D.	24. FUNERAL DIRECTOR: E. S. Boal	ADDRESS: Westernport, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

V0594

RECEIVED
MAR 27 1950
U. S.
BUREAU

Within corporate limits

02251

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) 56
HOSPITAL OR INSTITUTION OR STREET ADDRESS 419 Arch St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 419 Arch St.

3. NAME OF DECEASED (Type or Print): (First) Louis (Middle) A. (Last) Kabosky

4. DATE OF DEATH: (Month) 3/I/50 (Day) (Year) 19

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: 7/I0/I872 | 9. AGE last birthday: 77 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Machinist Rolled | 10b. KIND OF BUSINESS OR INDUSTRY: B&ORR | 11. BIRTHPLACE (State or foreign country): Germany | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob J Kabosky | 14. MOTHER'S MAIDEN NAME: Anna Deitze

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service) | 16. SOCIAL SECURITY NO.: 705098680 | 17. INFORMANT AND ADDRESS: Mrs. Matilda Gabeli Cumberland, M

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Chronic myocarditis	18 mon.
148 Antecedent cause(s)	(b) Carcinoma of Throat, left	2 1/2 yrs.
45 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY: (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug., 19 48, to Mar. 1, 19 50, that I last saw the deceased alive on Mar. 1, 19 50, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE: Clay R. Lantz | (Degree or title) M.D | ADDRESS: Cumberland. Md. | DATE SIGNED: 3/2/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 3/4/50 | NAME OF CEMETERY OR CREMATORY: St. Peter & Paul | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: March 2, 1950 | REGISTRAR'S SIGNATURE: Writes R. Lantz, M.D | 24. FUNERAL DIRECTOR: James F. Scarpelli | ADDRESS: Cumberland, Md

32647

RECEIVED
MAR 7 1950
BUREAU V. S.

02252

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place) 14 hours; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pa; COUNTY Cambria; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Johnstown; STREET ADDRESS (If rural, give location) 800 Central Ave

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Erwin	Earl	Keiper	3-28-50 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Married	Feb 4 1889	61 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Cottage Cobbler Co	Johnstown Pa.	U.S.A.

13. FATHER'S NAME Lewis Keiper

14. MOTHER'S MAIDEN NAME Delia Dunmyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	172-03-7928	Ralph Keiper

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral hemorrhage (apoplexy)	15 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio-vascular-renal disease	1 yr.
	(c) arteriosclerosis with hypertension	3 mo.

442
131a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H. V. Deming MD		Cumberland Md	3-28-1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	3-28-50	Johnstown Pa	Johnstown Cambria PA

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3-28-50	Mrs. Nancy V. Roe	John Henderson Co	Johnstown Pa

29879

RECEIVED
MAR 29 1950
U. S. A.
BUREAU

Within corporate limits

02253

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH· COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary	STREET ADDRESS (If rural, give location) 39 Humbird St.

3. NAME OF DECEASED (Type or Print)	(First) John	(Middle) Richard	(Last) Kline	4. DATE OF DEATH	(Month) (Day) (Year) 3-10-50 19
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Divorced	8. DATE OF BIRTH 4/17/1869	9. AGE last birthday 80 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron molder-Retired	10b. KIND OF BUSINESS OR INDUSTRY Foundry	11. BIRTHPLACE (State or foreign country) Berryville, Va.	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME John Henry Kline		14. MOTHER'S MAIDEN NAME Mary Jane Swartz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS Clarence Kline 39 Humbird St.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial failure	2 mo
Antecedent cause(s) 420.1	(b) Coronary sclerosis	2 yrs
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 12, 1950, to Mar. 10, 1950, that I last saw the deceased alive on Mar 8, 1950, and that death occurred at 12:01 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones M.D.		110 S. Centre St.	Mar. 10, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/13/50	Philos Cem.	Westernport, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 12, 1950	Winter R. Frantz, M.D.	James F. Scarpelli	Cumberland, Md.

33830

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 21 1950
BUREAU

DR. VAN ORMER

Within corporate limits

02254

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: WEST VIRGINIA — COUNTY: Grant
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: PETERSBURG
STREET ADDRESS (If rural, give location): 19 WATER STREET

3. NAME OF DECEASED (Type or Print): (First) LULA (Middle) M. (Last) KLINE

4. DATE OF DEATH: (Month) MARCH (Day) 29, (Year) 1950

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: JAN. 30, 1891

9. AGE last birthday: 59 yrs. — If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: HANNAH KELLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

260X 414K 61

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac failure — Interval Between Onset and Death: .

Antecedent cause(s) (b) Bronchial Pneumonia, acute — 1 week

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Chronic Valvular Heart Disease, probably rheumatic — ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 27 mos., 1950, to 29 mos., 1950, that I last saw the deceased alive on 29 mo., 1950, and that death occurred at 11:15 A.M., from the causes and on the date stated above.

SIGNATURE: Dr Alfred Van Ormer, M.D. — (Degree or title) — ADDRESS: Cumberland, Md — DATE SIGNED: 29 mos. 50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 3/31/50 — NAME OF CEMETERY OR CREMATORY: Maple Hall Hill — LOCATION (City, town, or county) (State): Petersburg W. Va.

DATE REC'D BY LOCAL REG.: March 30, 1950 — REGISTRAR'S SIGNATURE: Wister R. Hantz, M.D.

24. FUNERAL DIRECTOR: P. B. Zirkman & Son — ADDRESS: Petersburg West Virginia

RECEIVED
APR 4 1950
BUREAU V. S.

Within corporate limits

02255

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (In this place) 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Cumberland (Fairgo
STREET ADDRESS (If rural, give location) R.F.D.#6 Fairgo Cumberland Md.

3. NAME OF DECEASED (Type or Print): (First) Harvey (Middle) W. (Last) Knotts

4. DATE OF DEATH: (Month) March (Day) 19 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: June 13-1887

9. AGE last birthday: 62 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): mechanic helper

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Parsons W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Knotts

14. MOTHER'S MAIDEN NAME: Clara Fanster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217 10 5428

17. INFORMANT: Bertha Knotts, Rt. #6 City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
203 X Immediate cause	(a) Multiple myeloma with metastasis of the lungs	9 Mo.
55.2 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Bronchopneumonia-bilateral	?
	(c) Empyema-left lung	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland Md. March 19-1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Mar.22,1950 | NAME OF CEMETERY OR CREMATORY: Pleasant Vale Cemetery | LOCATION (City, town, or county) (State): Parsons, W. Va.

DATE REC'D BY LOCAL REG. March 22, 1950 | REGISTRAR'S SIGNATURE: Walter K. Beantz, M.D.

24. FUNERAL DIRECTOR | ADDRESS: William H. Kight Cumberland, Md.

9361/6

RECEIVED
MAR 28 1950
BUREAU V. S.

02256

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): 50 min.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 109 Wood St.

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) A. (Last) Langan

4. DATE OF DEATH: (Month) March (Day) 4 (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	Dec. 2-1924	25 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Manager, Queen City Candy Co.		Frostburg Md.	U.S.A.

13. FATHER'S NAME: John Langan

14. MOTHER'S MAIDEN NAME: Mary Ryan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 215-20-6520

17. INFORMANT: Dr. W.O. Mc Lane

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
816.5 **Immediate cause**	(a) Cerebral hemorrhage due to a fractured	50 min.
170c **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) skull from an automobile accident.	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Park Ave.	(CITY OR TOWN): Frostburg	(COUNTY): Allegany	(STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): March 4/50 7Pm.	INJURY OCCURRED While at work ☐ Not while at work ☒	HOW DID INJURY OCCUR? thrown out door of panel truck, after striking an auto & Bus.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.	Cumberland Md.	March 4-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	3-7-1950	St. Michael's Cemetery	Frostburg,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3-7-50	Mrs. Nancy N. Roe	Jacob Hafer	Frostburg, Md.

156 X2

RECEIVED
MAR 13 1950
BUREAU V. S.

Within corporate limits DR. ENFIELD

02257

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 5 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ECKHART
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) THOMAS (Middle) (Last) LEWIS

4. DATE OF DEATH: (Month) MARCH (Day) 31 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: 3/5/1878

9. AGE last birthday: 72 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT

10b. KIND OF BUSINESS OR INDUSTRY: Self-Retail

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM LEWIS

14. MOTHER'S MAIDEN NAME: ANNA PRICE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL -CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Bronchopneumonia

511.0 Antecedent cause(s)

1176 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Gastric Resection

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Myocardial Degeneration

19a. DATE OF OPERATION: 3/24/50

19b. MAJOR FINDINGS OF OPERATION: Duodenal ulcer, Completed Gastrectomy

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/20, 1950, to 3/31, 1950, that I last saw the deceased alive on 3/31, 1950, and that death occurred at 12:7 AM m., from the causes and on the date stated above.

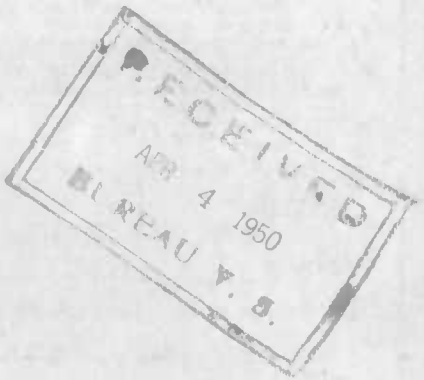
SIGNATURE: A E Enfield (Degree or title) ADDRESS: Cumberland DATE SIGNED: 4/1/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 4-3-50 — NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: April 2, 1950 — REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR: J. R. Durst — ADDRESS: Frostburg Md

29879


RECEIVED
APR 4 1950
BUREAU V. S.

Outside City Limits

Murray

02258

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Rt 40 Six Mile House

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
STREET ADDRESS (If rural, give location) US Rt 40 Six Mile House

3. NAME OF DECEASED (Type or Print) (First) George (Middle) L (Last) Longerbeam

4. DATE OF DEATH (Month) March (Day) 12 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH March 15, 1914
9. AGE last birthday 35 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Keeper
10b. KIND OF BUSINESS OR INDUSTRY Food
11. BIRTHPLACE (State or foreign country) Cumberland Md
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Archibald Longerbeam
14. MOTHER'S MAIDEN NAME Etta L. McBride

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None.
17. INFORMANT AND ADDRESS Mrs Paul Beveridge

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	2 months
592 Antecedent cause(s)	(b) Hypertension Heart Disease	2 years
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Chronic Nephritis	2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1948, to March 12, 1950, that I last saw the deceased alive on March 11, 1950, and that death occurred at 2.40 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) F. Alan G. Murray M.D. ADDRESS Cumberland, Md. DATE SIGNED March 14-50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE 3-16-50
NAME OF CEMETERY OR CREMATORY Green Hill Cem
LOCATION (City, town, or county) (State) Berryville Virginia

DATE REC'D BY LOCAL REG. March 15, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland Md

15671

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 21 1950
BUREAU

Within corporate limits

R. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02259

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 413 SOUTH ST.,

3. NAME OF DECEASED (Type or Print): CECIL A MAIER

4. DATE OF DEATH: MARCH 3 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: MAR. 29 1886

9. AGE last birthday: 63 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R & O R.R. Locomotive Engineer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): W.VA. Tunnelton

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: JOHN MAIER

14. MOTHER'S MAIDEN NAME: LAURA PHILLIPS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-07-6759

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial Failure	48 hrs
422.2 **Antecedent cause(s)**	(b) Chronic Myocarditis	3 yrs
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/13/50, 19....., to 3/3/50 19....., that I last saw the deceased alive on 3/2/50, 19....., and that death occurred at 8:40 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): O. R. Williams — **ADDRESS**: Cumberland, Md. — **DATE SIGNED**: 3/3/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — **DATE**: Mar 6 1950 — **NAME OF CEMETERY OR CREMATORY**: Hill Crest Cemetery — **LOCATION** (City, town, or county) (State): Cumberland, Md.

DATE RECD BY LOCAL REG.: March 5, 1950 — **REGISTRAR'S SIGNATURE**: Winter R. Frantz, M. D.

24. FUNERAL DIRECTOR — **ADDRESS**: William H. Kight Cumberland, Md.

32247

RECEIVED
MAR 14 1950
BUREAU V. S.

02260

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and OR TOWN give nearest town): Rural; LENGTH OF STAY (in this place): 1 1/2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Christie Rd. Minke's Cottage Inn

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: W.Va.; COUNTY: Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fort Ashby
STREET ADDRESS (If rural, give location): ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Rosalie	Dorothy	Malone	March 26 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	white	single	April 4-1927	22 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sewing machine operator	Undergarment Factory	Ridgely W.Va.	U.S.A.

13. FATHER'S NAME: Clarence M.Malone
14. MOTHER'S MAIDEN NAME: Nellie Dorothy Gower

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	234-40-2861	Clarence M.Malone

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) intracranial hemorrhage due to	about 3 minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Ruptured congenital aneurysm of the anterior	
754.6 1571	(c) cerebral vessel, right side.	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?		

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H. V. Deming M.D.	Cumberland Md.	March 26-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/28/50	Fort Hill Cemetery	Ft. Ashby W.Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 27, 1950	Wendell K. Frantz, M.D.	John J. Hafer	Cumberland, Md.

49606

VS. A15A T

RECEIVED
APR 4 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02261

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH: COUNTY Allegheny; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg, Md.
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing Rd. #1
STREET ADDRESS (If rural, give location) Rural ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
ANNA	MAE	MASON	March 18 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	White	Married	Feb 28, 1902	48 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	House work	Frostburg, Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Rizer	Elizabeth Rizer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
	none	George Mason

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Diabetec Coma.	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Diabetes	2
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Bright's Disease	2

260 ✓ 61

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 3-17, 1950, to 3-18, 1950, that I last saw the deceased alive on 3-17, 1950, and that death occurred at 6:45 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Adolf Wolfenman M.D.		Frostburg	3-18-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	March 21, 1950	Mount Zion	Grantsville, Rural Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3-21-50	Wm Harvey H. Roe	Allen Winebrenner	GrantsvilleMd

RECEIVED
MAR 24 1950
MT. DEAD V. A.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02262

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (In this place) 62 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 243 Columbia St.

3. NAME OF DECEASED (Type or Print): (First) Thomas (Middle) H. (Last) Maus
4. DATE OF DEATH: (Month) March (Day) 4 (Year) 1950

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: May 3 1887
9. AGE last birthday: 62 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Coal Room Repr.
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Maus
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If year, give war or dates of service): WWI
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Greyle Brown Maus,

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 **Immediate cause** (a) Arteriosclerotic heart disease — 7 years

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hemorrhage from bowel, due to unknown cause — 2 days

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 1, 1950, to Mar 4, 1950, that I last saw the deceased alive on Mar 3, 1950, and that death occurred at 4:10 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
R. W. Trewaski's, Dr | Cumberland, Md | Mar 4-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Mar 7 50 | NAME OF CEMETERY OR CREMATORY: St Peter & Pauls Cem | LOCATION (City, town, or county): Cumberland (State): Md

DATE REC'D BY LOCAL REG.: March 6, 1950 | REGISTRAR'S SIGNATURE: Winter L. Kantz, M.D. | 24. FUNERAL DIRECTOR: Louis Stein, Inc., | ADDRESS: Cumberland

156 -90

RECEIVED
AUG 14 1950
BY U.S. ARMY

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

03502

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 10 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Sylvan Retreat

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
STREET ADDRESS (If rural, give location): Maryland Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Benjamin	Franklin	McCarthy	Mar	21	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
M	W	Widowed	Dec. 5, 1876	73 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Paper Finisher	Paper Mill	Hancock Md	USA

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	216-05-9670	Sylvan Retreat

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 **Immediate cause** (a) Congestive Heart Failure — Interval Between Onset and Death: 10 days

940 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary sclerosis — 2 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Mar. 25, 1949, to Mar. 21, 1950, that I last saw the deceased alive on Mar. 18, 1950, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones M.D.	110 S. Centre St.	Mar. 23, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/24/50	St. Peter's Cemetery	Westernport Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 24, 1950	Walter R. Hartz, M.D.	Ellsworth S. Boal	Westernport, Md.

49613

RECEIVED
MAR 28 1950
BUREAU U. S.

Within corporate limits

02263

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (In this place): 26 Hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 143 N. Center St.

3. NAME OF DECEASED (Type or Print): (First) Frank (Middle) B. (Last) McCallum
4. DATE OF DEATH: (Month) March (Day) 2 (Year) 1950

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): divorced
8. DATE OF BIRTH: April-10-1885
9. AGE last birthday: 64 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Veterinarian
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Scotland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank McCallum
14. MOTHER'S MAIDEN NAME: Marjory Buchanan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.I
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. C. Dale Fridley (daughter)

Brigs, Capt.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Lobar pneumonia (bilateral) — about 2 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: fractured nose & fatty liver.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H. V. Deming M.D. H. V. Deming M.D. Cumberland Md. March 2-1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Mar. 5, 1950
NAME OF CEMETERY OR CREMATORY: Rose Hill
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: March 4, 1950
REGISTRAR'S SIGNATURE: Winter K. Dantz, M.D.
24. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.

V5092

RECEIVED
MAR 7 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02264

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 48 N. Mechanic St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Clarence	R	McDermott	3	26	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Separated	3/27/80	69 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter	Homes	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George McDermott	Matilda Hines

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	217-14-4136	Mrs. Margaret McDermott

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
450.1, Immediate cause	(a) Acute Myocardial Failure	1½ hrs
Antecedent cause(s)		
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis	2 yrs
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

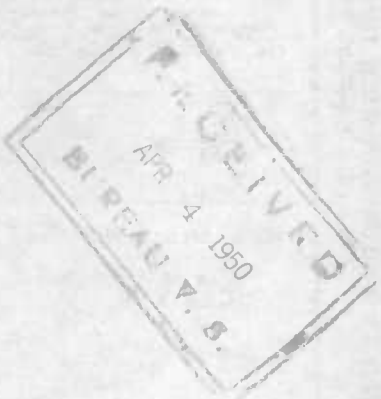
22. I hereby certify that I attended the deceased from Nov 19, 1949, to Mar 26, 1950, that I last saw the deceased alive on Mar. 24, 1950, and that death occurred at 11:40 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M.D.	110 S. Centre St.	Mar. 27, 1950

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Mar 29 50	St Peter & Paul Cy	Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 28, 1950	Walter L. Kantz, M.D.	Louis Stein Inc	" "

458 V9


RECEIVED
APR 4 1950
BUREAU V. S.

Dr. W. McLane
02265

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): W. Main St.

3. NAME OF DECEASED (Type or Print): (First) EMMA (Middle) MARIA (Last) McGUIRE
4. DATE OF DEATH: (Month) March (Day) 27, (Year) 1950

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: 1-20-1947
9. AGE last birthday: 3 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James McGuire
14. MOTHER'S MAIDEN NAME: Maria DellaRocca

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: James McGuire, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

590 x **Immediate cause** (a) Acute Nephritis, Acute Cystitis — 3 Day

Antecedent cause(s)

133a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ____

(c) Convulsions — 4 Hrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐:
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 25, 1950, to Mar. 27, 1950, that I last saw the deceased alive on Mar. 27, 1950 and that death occurred at 5:30 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. McLane MD		Frostburg Md	3-28-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3-30-50	St. Michaels Cem.	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3-29-50	Wm. Harvey H. Poe	J. R. Durst	Frostburg, Md.

VS/A15

RECEIVED
APR 3 1950
BUREAU U. S.

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02266

FILM No. G 124 MAR 23 1950

CERTIFICATE OF DEATH

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing
STATE: MARYLAND
LENGTH OF STAY (In this place): 23 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: ~

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing
STREET ADDRESS (If rural give location): Douglas Ave.

3. NAME OF DECEASED (Type or Print): (First) George (Middle) M. (Last) Murdo

4. DATE OF DEATH: (Month) Mar. (Day) 7th (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Nov 25 1884

9. AGE last birthday: 65 6 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto. Line Worker

10b. KIND OF BUSINESS OR INDUSTRY: Auto Plant

11. BIRTHPLACE (State or foreign country): Kansas City (U.S.)

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Samuel M. Murdo

14. MOTHER'S MAIDEN NAME: Emily Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 164-10-3100

17. INFORMANT: Mrs. Emily M. Murdo

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion —

420.1 94a

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis

(c)

INTERVAL BETWEEN ONSET AND DEATH: (a) — (b) 12 hrs.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.: —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN) (COUNTY) (STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour): —

INJURY OCCURRED While at Work ☐ Not While At work ☐: —

HOW DID INJURY OCCUR?: —

22. I hereby certify that I attended the deceased from 3/7, 1950, to 3/12, 1950, that I last saw the deceased alive on 3/7, 1950, and that death occurred at 11:30 A m., from the causes and on the date stated above.

SIGNATURE: Paul Eugene Joyce (Degree or title) M.D. ADDRESS: Lonaconing Md DATE SIGNED: 3/10/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: March 10, 1950

NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery

LOCATION (City, town, or county) (State): Moscow, Md

DATE REC'D BY LOCAL REG.: 3/10/50

REGISTRAR'S SIGNATURE: Jannette M Pool

24. FUNERAL DIRECTOR: M. Eichhorn

ADDRESS: Lonaconing, Md

9842V

RECEIVED
MAR 20 1950
BUREAU V. S.

Within corporate limits

02267

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md
STREET ADDRESS (If rural, give location) 943 Gay St.

3. NAME OF DECEASED (Type or Print) (First) David (Middle) M. (Last) McSorley

4. DATE OF DEATH (Month) 3/30/50 (Day) (Year) 19

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH 6/II/49
9. AGE last birthday [redacted] If under 1 year Months 9 Days 11 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph G. McSorley
14. MOTHER'S MAIDEN NAME Kathaleen L. Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT Joseph G. McSorley Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

492 X Immediate cause (a) Virus Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 1 day

109 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-30, 1950, to 3-30, 1950, that I last saw the deceased alive on 3-30, 1950 and that death occurred at 10 20/A m., from the causes and on the date stated above.

SIGNATURE H A Eliason (Degree or title) ADDRESS 126 Union St. Cumberland Md DATE SIGNED 3-30-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 4/I/50
NAME OF CEMETERY OR CREMATORY St Peter & Paul's
LOCATION (City, town, or county) (State) Cumberland, Md

DATE REC'D BY LOCAL REG. March 31, 1950
REGISTRAR'S SIGNATURE Wrater R. Frantz, M.D.
24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS 108 Va Ave Cumberland, Md.

2-0-6-11-9-31-6-40-9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 4 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02268

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Wrights Crossing

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): Wrights Crossing

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
SADIE	(McCLINTOCK)	MEAGHER	March	12,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
female	white	married	6-27-1880	69 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Pennsylvania	USA

13. FATHER'S NAME: Mitchell McClintock

14. MOTHER'S MAIDEN NAME: Matilda Gears

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mrs. Leona Layman, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) pulmonary edema	1 hour
420.0 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerotic heart disease	2 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 3-12, 1950, to 3-12, 1950, that I last saw the deceased alive on 3-12, 1950, and that death occurred at 9 25 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
L. Wolferman	M.D.	Frostburg	3-13-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	3-15-50	Allegany Cemetery	Frostburg	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3-15-50	Mrs. Nancy N. Roe	J. R. Durst,	Frostburg, Md.

VS-A15

RECEIVED
MAR 21 1950
BUREAU U. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02269

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: ALLEGANY; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND; LENGTH OF STAY (in this place): 65 YEARS; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 9 Ridgeway Terrace

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; STREET ADDRESS (If rural give location): 9 Ridgeway Terrace

3. NAME OF DECEASED (Type or Print): (First) Bessie (Middle) Lee (Last) Miller

4. DATE OF DEATH: (Month) MARCH (Day) 5 (Year) 1950

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: 11-13-1884

9. AGE last birthday: 65 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JACOB VALENTINE

14. MOTHER'S MAIDEN NAME: MARY ELIZABETH WEST

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: None

17. INFORMANT: HAROLD MILLER - SON

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) DIABETIC COMA	2 DAYS
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) DIABETES MELLITUS	6 YEARS
	(c)	

260 / 61

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased ~~from~~ ON 3-5, 1950, to —, 19....., that I last saw the deceased alive on 3-5, 1950, and that death occurred at 8:10 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

R. W. Ballin, M.D. 62 GREENE ST CUMBERLAND 3-5-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Mar 8 1950 | NAME OF CEMETERY OR CREMATORY: Zion Memorial Cem. | LOCATION (City, town, or county) (State): Near Cumberland Md

DATE REC'D BY LOCAL REG.: March 7, 1950 | REGISTRAR'S SIGNATURE: A. P. Krantz, M.D. | 24. FUNERAL DIRECTOR ADDRESS: John J Hafer Cumberland Md.

RECEIVED
DEC 14 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02270

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 70 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 311 Valley St.	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 311 Valley St.
3. NAME OF DECEASED (Type or Print): (First) Caroline (Middle) W. (Last) Miller	4. DATE OF DEATH: (Month) March (Day) 24 (Year) 1950
5. SEX: Female	6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Aug 11 1879
9. AGE last birthday: 70 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Cumberland Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Michael Reig	14. MOTHER'S MAIDEN NAME: Caroline Miller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Mrs Virgil H. Llewellyn.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pulmo Cardial Failure	30 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension cardio vascular disease	5 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1946, to Mar 24, 1950, that I last saw the deceased alive on Mar 23, 1950, and that death occurred at 4:15 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F Daniels	M.D.	110 S. Centre St.	Mar. 25, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Mar 27 '50	St Peter & Paul Cem	Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 27, 1950	Winter K. Lantz, M.D.	Louis Stein Sons	" "

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 4 1950
BUREAU U. S.

DR. ELIASON

Within corporate limits

02271

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: MARYLAND COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place): 49 YRS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND,
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): 827 VIRGINIA AVENUE

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
EVA	INEZ	MILLER	MARCH	15	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
FEMALE	WHITE	MARRIED	OCT. 18 1900	49 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Cumberland Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WM. BOYD KRIM	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
No		None	MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	2 days
Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio Sclerosis Hypertension	3 yrs.
	(c)	

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II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
No				

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-12, 1950, to 3-15, 1950, that I last saw the deceased alive on 3/15, 1950, and that death occurred at 5:10 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H W Eliason MD		126 Henson St Cumberland Md	3/16/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Mar. 18 50	Rose Hill Cem	Cumberland	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 18, 1950	Hunter R Trantz MD	Louis Stein Inc	Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

M

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RECEIVED
MAR 21 1950
BUREAU V. S.

Within corporate limits

M

02272

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH· COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary	STREET ADDRESS (If rural, give location) 132 N. Centre Street

3. NAME OF DECEASED (Type or Print)	(First) James	(Middle) Ross	(Last) Mortimore	4. DATE OF DEATH	(Month) 3 (Day) 10 (Year) 1950
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH About Aug 1883	9. AGE last birthday 66 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Laborer	11. BIRTHPLACE (State or foreign country) Manns Choice, Pa.	12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME James Ross Mortimore		14. MOTHER'S MAIDEN NAME Margaret Griffith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service)	16. SOCIAL SECURITY No. 218-16-3861	17. INFORMANT AND ADDRESS Mrs. Alva Twigg Rt. II Cumb'd Md			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Broncho pneumonia	3 days
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

491 K
107

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 1, 1950, to Mar. 10, 1950, that I last saw the deceased alive on Mar. 10, 1950, and that death occurred at 2:30 p m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones M.D.		110 S. Centre St.	Mar. 11, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	3-12-50	Manns Choice Cem	Manns Choice	Pa

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 12, 1950	Wrater R. Kantz, M.D.	Louis Stein Inc	Cumberland

866VV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
MAR 21 1950
BUREAU OF

Within corporate limits

02273

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland, LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland,
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hosp.	STREET ADDRESS (If rural, give location): 218 Cumberland St.,

3. NAME OF DECEASED (Type or Print)	(First) MABEL	(Middle) ATHEY	(Last) MURRAY	4. DATE OF DEATH (Month) Mar. (Day) 5, (Year) 1950	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: Aug. 16, 1870	9. AGE last birthday: 79 yrs.	If under 1 year: Months. Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Substitute Teaching	10b. KIND OF BUSINESS OR INDUSTRY: Education	11. BIRTHPLACE (State or foreign country): Hancock, Md.	12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME: Emanuel Athey	14. MOTHER'S MAIDEN NAME: Emma L. Potts				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT AND ADDRESS: Mrs. Ruth Murray 555 Paterson Ave.,			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinomatosis	2 mos
170 X Antecedent cause(s)	(b) Carcinoma of l. breast	8 yrs.
50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-4, 1942, to 3-5-, 1950, that I last saw the deceased alive on 3-4-50 19....., and that death occurred at 5:20 Am m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. Kummerman	M.D.	Cumberland Md	3-6-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 3/7/50	NAME OF CEMETERY OR CREMATORY: Rose Hill Cem.	LOCATION (City, town, or county) (State): Cumberland, Md.
DATE REC'D BY LOCAL REG.: March 7, 1950	REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR: Charles L. George	ADDRESS: Cumb. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

V3491

RECEIVED
MAR 14 1950
BUFFALO, N. Y.

Within corporate limits Br 1193

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02274

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 825 Harvard Ave.,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland,
STREET ADDRESS (If rural, give location): 825 Harvard Ave.,

3. NAME OF DECEASED (Type or Print): (First) CATHERINE (Middle) (Last) NEVY

4. DATE OF DEATH: (Month) March (Day) 20, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: June 5, 1888

9. AGE last birthday: 61 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Berceto, Italy

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Michael Isoni

14. MOTHER'S MAIDEN NAME: Mary Ianelli

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Robert A. Nevy 825 Harvard Ave., (Son

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
420.0 Immediate cause	(a) congestive heart failure	6 weeks
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerotic heart disease	2 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-4, 1949, to 3-20, 1950, that I last saw the deceased alive on 3-19, 1950, and that death occurred at 5.00 a.m., from the causes and on the date stated above.

SIGNATURE: L. Rhinos (Degree or title) MD ADDRESS: 57 Greene St. DATE SIGNED: 3-21-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 3/22/1950
NAME OF CEMETERY OR CREMATORY: St. Mary's Cem.
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: March 22, 1950
REGISTRAR'S SIGNATURE: Walter K. Frantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.

RECEIVED
MAR 28 1950
BUREAU V. S.

Evidence for addition in #21 shonw on;

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02275

FILM No. G 12 MAY 1 1950

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Midland (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Catherine H. O'Brien

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Patrick O'Brien

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): October 12, 1889

8. AGE: Years 60 | Months 5 | Days 9 | If less than one day ... hrs. ... min.

9. Birthplace: Klondike, Maryland (Town, county, and state)

10. Usual occupation: House Work

11. Industry or business: Own Home

FATHER: 12. Name: John Coleman

13. Birthplace

MOTHER: 14. Maiden name: Ellen Tighe

15. Birthplace

16. Informant: Beatrice Campbell

Address: Midland, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 24, 1950 (month) (day) (year)

Cemetery or crematory: Belvedere Cemetery

Location: Midland, Maryland.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Maryland.

19. 3-23 1950 Nancy N. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-21 1950, at 8:20 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 27 1950, to March 21 1950 and that I last saw h. ... alive on March 20 1950

Immediate cause of death	DURATION
cerebral hemorrhage	2 hours
Due to: Hypertension	10 years
Due to: Arteriosclerosis	?
Other conditions: 331 x Aneurism of Aorta, 96 (Include pregnancy within 3 months of death)	?

Major findings of operations: nonsyphilitic (5/1/1950 akc) Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: A. Wolferman M.D. M. D. or other

Address: Frostburg, Md. Date signed 3-21-50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
MAR 27 1950

Within corporate limits

DR. DURRETT

-27-

02276

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND,
STREET ADDRESS (If rural, give location): QUEEN CITY PAVEMENT

3. NAME OF DECEASED (Type or Print): (First) WILLIS (Middle) E. (Last) PARK

4. DATE OF DEATH: (Month) MARCH (Day) 15 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): SINGLE

8. DATE OF BIRTH: FEB. 20, 1879

9. AGE last birthday: 71 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: BENJAMIN F. PARK

14. MOTHER'S MAIDEN NAME: MARY ANN ROY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis	Acute
420.1 Antecedent cause(s) 131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis + Nephritis	6 mos.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN):
(COUNTY):
(STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 14, 1950, to Mar 15, 1950, that I last saw the deceased alive on Mar. 15, 1950, and that death occurred at 5:05 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Clark K. Durrett M. D. — ADDRESS: Cumberland — DATE SIGNED: 3/16/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 3-17-50 — NAME OF CEMETERY OR CREMATORY: Hillcrest Mem — LOCATION (City, town, or county): Cumberland (State): Md

DATE RECD BY LOCAL REG.: March 17, 1950 — REGISTRAR'S SIGNATURE: Walter K. Frantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: Long Stein Inc Cumberland

KV599

VS. A15

RECEIVED
MAR 21 1950
BUREAU U. S.

Dr. Bringe

02277

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rawlings — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rawlings
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Postoffice R.D.# 3 Keyser, W. Va.	STREET ADDRESS: Postoffice (If rural, give location) R.D.# 3 Keyser, W. Va.

3. NAME OF DECEASED (Type or Print)	(First) Mabel	(Middle) Wilson	(Last) Parsons	4. DATE OF DEATH (Month) (Day) (Year) Mar. 12, 1950
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced	8. DATE OF BIRTH: Mar. 14, 1902	9. AGE last birthday: 47 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Harrisville, W. Va.	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: Loe Ray Wilson		14. MOTHER'S MAIDEN NAME: Anna Prunty		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)	16. SOCIAL SECURITY No.: None	17. INFORMANT AND ADDRESS: John Parsons R.D.# 3 Keyser, W. Va.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
153	Immediate cause	(a) Cancer of the large intestine (sigmoid)	1 year
46e	Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) —	
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: 3-1-49	19b. MAJOR FINDINGS OF OPERATION: cancer of sigmoid, liver metastases	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-28-, 1949, to 3-12, 1950, that I last saw the deceased alive on 3-10-, 1950, and that death occurred at 1 30 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
L Wrings MD		57 Greene St	3-14-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Mar. 15, 1950	NAME OF CEMETERY OR CREMATORY: Odd Fellows Cem.	LOCATION (City, town, or county) (State): Harrisville, W. Va.
DATE REC'D BY LOCAL REG.: March 14, 1950	REGISTRAR'S SIGNATURE: [signature]	24. FUNERAL DIRECTOR: Charles L. George	ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 17 1950
BUREAU V. S.

Within corporate limits

02278

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 118 Bedford St

3. NAME OF DECEASED (Type or Print): (First) Alexander (Middle) (Last) Patton
4. DATE OF DEATH: (Month) March (Day) 25 (Year) 1950
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: April 8 1863
9. AGE last birthday: 66 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Whole Sale Groceries
11. BIRTHPLACE (State or foreign country): Pittsburgh, Pa
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service): —
16. SOCIAL SECURITY No.: 214-05-5810
17. INFORMANT AND ADDRESS: Mrs Ethel White Patton, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 Immediate cause (a) Pulmonary Edema — 3 days

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Myocardial failure — 4 days

(c) Coronary sclerosis — 6 mos

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive & Arteriosclerotic heart disease — 2 yrs

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): No — (CITY OR TOWN) — (COUNTY) No — (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour): No m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? No

22. I hereby certify that I attended the deceased from 10/28, 1949, to March 25, 1950, that I last saw the deceased alive on March 25, 1950, and that death occurred at 9 40 P.m., from the causes and on the date stated above.

SIGNATURE: Saville G. Weisman MD — (Degree or title) — ADDRESS: 122 Bedford St Cumberland, Md — DATE SIGNED: 5/27/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial & Removal — DATE: Mar. 27, 50 — NAME OF CEMETERY OR CREMATORY: Union Dale Cem. — LOCATION (City, town, or county): Allegheny — (State): Pa.

DATE REC'D BY LOCAL REG.: March 27, 1950 — REGISTRAR'S SIGNATURE: Wruter R. Wantz, M.D. — 24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland

27560

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 4 1950
BUREAU V. S.

Within corporate limits

02279

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 10Yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 515 Dunbar Drive	STREET ADDRESS (If rural, give location): 515 Dunbar Drive

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Alfretta Pierce

4. DATE OF DEATH (Month) (Day) (Year): 3/19/50 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months / Days	If under 24 hrs. Hours / Min.
F	W	Widowed	2/22/1860	90 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Fort Wayne Ind.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Claude N. Martin	Elizabeth A. Cummings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Paul R. Martin-Dillon Cumberland,

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

442 Immediate cause (a) Hypertensive C.V. Renal Disease — years

Antecedent cause(s)

131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1949, to March 19, 1950, that I last saw the deceased alive on March 14, 1950, and that death occurred at 7:00 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): B. M. Schindler Md. — ADDRESS: 41 Green St Cumberland Md. — DATE SIGNED: March 20 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/23/50	I.O.F. Cem.	Marion Ind.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
March 20, 1950	Winter R. Frantz, M.D.	James F. Scarpelli Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 28 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

(02280)

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 18 N. Grant St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 18 N. Grant St.

3. NAME OF DECEASED (Type or Print): (First) MARGARET (Middle) ELLEN (Last) PRESSMAN

4. DATE OF DEATH: (Mooth) March (Day) 6, (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: 9-8-1870

9. AGE last birthday: 79 yrs. If under 1 year Mooths. Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Mt. Savage, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Patrick Farrell

14. MOTHER'S MAIDEN NAME: Catherine Garrity

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo, or uoknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: Wm. Pressman, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

444 X Immediate cause (a) Chr Nephritis — Interval Between Onset and Death: ? ?

131 b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — several years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 6, 1950, to Mar 6 1950, that I last saw the deceased alive on Mar 5, 1960, and that death occurred at 1:40 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Wm Lane Md Frostburg Md 3-6-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 3-9-50 | NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery | LOCATION (City, town, or county) (State) Frostburg, Md.

DATE REC'D BY LOCAL REG 3-7-50 | REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR ADDRESS J. R. Durst, Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 13 1950
BUREAU V. A.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

02281

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton, Md.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) (Last) Preston

4. DATE OF DEATH: (Month) 3 (Day) 27 (Year) 1950

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 5/6/71

9. AGE last birthday: 78 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Meshach Preston

14. MOTHER'S MAIDEN NAME: Annie Greenhorn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 5

17. INFORMANT AND ADDRESS: daughter

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 X **Immediate cause** (a) Cerebral Vascular Accident — Interval Between Onset and Death: 5 days

Antecedent cause(s)
830 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) General Arteriosclerosis — 3 yrs
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 7, 1950, to Mar. 27, 1950, that I last saw the deceased alive on Mar. 24, 1950, and that death occurred at 3:15 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

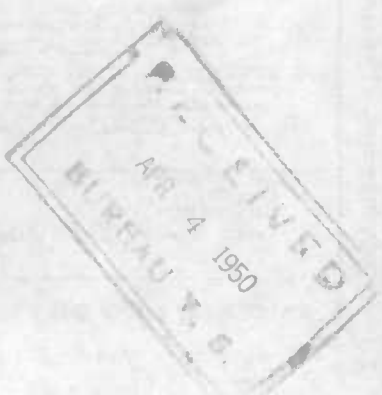
Arthur F. Jones M.D. — 110 S. Centre St. — Mar. 27, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: March 29, 1950 — NAME OF CEMETERY OR CREMATORY: Laurel Hill — LOCATION (City, town, or county) (State): Moscow, Maryland

DATE REC'D BY LOCAL REG.: March 26, 1950 — REGISTRAR'S SIGNATURE: Winter K. Fantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: Ellsworth S. Boal, Westernport, Md.

45402


RECEIVED
APR 4 1950
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

02282

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place) 7 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellerslie
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Nancy (Middle) E (Last) Printy

4. DATE OF DEATH (Month) March (Day) 31 (Year) 1950

5. SEX Female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow
8. DATE OF BIRTH Dec.10-1878
9. AGE last birthday 71 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Berkley Springs W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Micheal Pethoney
14. MOTHER'S MAIDEN NAME Francis Parker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Raymond Rider

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
570.2 Immediate cause	(a) Gangrene of the bowel due to	7 days
186a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Mesenteric thrombosis also had bronchopneumonia & edema of the brain(marked)	7 days
	(c) Fracture of the nasal bone	7 days

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY home
(CITY OR TOWN) Ellerslie (COUNTY) Allegany (STATE) Md.
TIME (Month) (Day) (Year) (Hour) OF INJURY March 24-1950 9 A m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Standing up in living room, dizzy, fell to floor, fractured nose.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. H. V. Deming M.D. (Degree or title) ADDRESS Cumberland Md. DATE SIGNED March 31-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 4/2/1950
NAME OF CEMETERY OR CREMATORY Greenway Cemetery
LOCATION (City, town, or county) (State) Berkley Spring W.Va.

DATE REC'D BY LOCAL REG. April 2, 1950
REGISTRAR'S SIGNATURE Wrutes R. Lantz, M.D.
24. FUNERAL DIRECTOR Harvey H. Zeigler ADDRESS Hyndman, Pa.

903.0

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
APR 4 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02283

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) Borden Mines

3. NAME OF DECEASED (Type or Print): (First) OSBORNE (Middle) (Last) RANKIN

4. DATE OF DEATH: (Month) March (Day) 23, (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 9-23-1890

9. AGE last birthday: 59 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal mines

11. BIRTHPLACE (State or foreign country): Borden Mines, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Rankin

14. MOTHER'S MAIDEN NAME: Margaret Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: Mrs. Lavern Kerr, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Nephritis (Cardiovascular-renal disease) — Years

442 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic Myocarditis & Hypertension — Years

1310 (c) Arteriosclerosis — Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: NONE

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): NONE

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): NONE m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MARCH 18, 1950, to MARCH 23, 1950, that I last saw the deceased alive on MARCH 23, 1950, and that death occurred at 1:40 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Martin Goldstein M.D. 48 Broadway, Frostburg Md. 3/24/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 3-26-50 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 3-26-50 — REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR ADDRESS: J. R. Durst, Frostburg, Md.

45402

RECEIVED
MAR 29 1950
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

02284

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: in, Auto. in route to Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: W.Va. COUNTY: Preeabriar; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Renick; STREET ADDRESS (If rural, give location): visiting at Cumberland Md 213 Washington St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Wilbert	Elmo	Reinhold	March	23	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	single	Oct. 30-1947	2 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Renick Renick W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Quentin Reinhold

14. MOTHER'S MAIDEN NAME: Mary Lilly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Quentin Reinhold, Renick, W. Va

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
468.1	Immediate cause	(a) Bronchopneumonia (bilateral)	about 2 days.
107	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Mesenteric lympho-adenitis (marked)	?
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: noturol causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D.	H.V. Deming M.D.	Cumberland Md.	March 24-1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	March 27, 1950	Renick Cemetery	Renick W. Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 25, 1950	Winter R. Frantz, M.D.	Louis Stein, Inc.	Cumberland, Maryland.

VS. A15A

RECEIVED
MAR 28 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

02285

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place) 30 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Kelley-Springfield Tire Co Plant	STREET ADDRESS (If rural, give location) 22 West First St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Francis	Xavier	Reitmeier	March	9	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	white	married	Nov. 8-1880	69 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Steam tender, rubber curer	K.S.Tire Co.	Bavaria Germany	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Bartholmew Reitmeier	Barbara Reisinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	214-05-5629	Melisea E. Eversole Reitmeier

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion due to	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
420.1 93d	(c) Chronic myocarditis	About 5 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H. V. Deming M.D.	Cumberland Md.	March 9-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/13/50	St Peter & Paul's Cem	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 10, 1950	Winter L. Hantz, M.D.	James F. Scarpelli	Cumberland, Md.

VS. A15A

496 2V

RECEIVED
MAR 14 1950
BUREAU U. S.

Within corporate limits: Yes
Arthur Jones

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02286

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 52 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Sylvan Retreat

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): (Committed to Sylvan Retreat in 1895 by Court)

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) (Last) Rice

4. DATE OF DEATH: (Month) March (Day) 29 (Year) 1950

5. SEX: F

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: about 1869

9. AGE last birthday: 80 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY?: ?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: " ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Sylvan Retreat Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial failure	15 min
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	10 yrs
	(c)	

420.1
940

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from Dec, 1946, to Mar 29, 1950, that I last saw the deceased alive on Mar 24, 1950, and that death occurred at 6:45 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur J. Jones	M.D.	110 S. Centre St.	Mar. 31, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/31/50	Allegany County Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 31, 1950	Winter R. Krantz, M.D.	John J. Hofer, Cumberland, Md.	

RECEIVED
APR 4 1950
BUREAU V. B.

02287

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 2 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 106 Bowery St

3. NAME OF DECEASED (Type or Print) (First) Nellie (Middle) (Last) Richardson
4. DATE OF DEATH (Month) 3 (Day) 19 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 9-2-1899
9. AGE last birthday 70 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Vale Summit Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Martin Lavelle
14. MOTHER'S MAIDEN NAME Margaret Finn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Mrs. Rana Richardson, 106 Bowery St, Frostburg, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinoma of Liver	
157x Antecedent cause(s)	Probably primary in	3½ mo
46g Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) pancreas	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 1, 1949, to Mar 19, 1950, that I last saw the deceased alive on Mar 18, 1950, and that death occurred at 12:10 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. O. McLane MD
ADDRESS Frostburg Md
DATE SIGNED 3-20-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 3-21-50
NAME OF CEMETERY OR CREMATORY St. Michael's Cem
LOCATION (City, town, or county) Frostburg (State) Md

DATE REC'D BY LOCAL REG. 3-21-50
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hafer
ADDRESS Frostburg, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 24 1950

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02288

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 72 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 223 N. Lee St.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 223 N. Lee St.

3. NAME OF DECEASED (Type or Print): (First) Martin (Middle) (Last) Rohman

4. DATE OF DEATH: (Month) March (Day) 30 (Year) 1950

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: April 22 1877
9. AGE last birthday: 72 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipping Clerk - Retired
10b. KIND OF BUSINESS OR INDUSTRY: Brewery
11. BIRTHPLACE (State or foreign country): Cumberland Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Casper Rohman.
14. MOTHER'S MAIDEN NAME: Matilda Chrbar.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If year, give war or dates of service)
16. SOCIAL SECURITY No.: 214-05-4797
17. INFORMANT AND ADDRESS: Martin Rohman Jr Cumbd Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

442 x Immediate cause (a) Cardio - Vascular - Renal Disease — 10 years

Antecedent cause(s)

131 a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1940, to 3-30, 1950, that I last saw the deceased alive on 3-30, 1950, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

SIGNATURE: J. Johnson (Degree or title) J.M.D. — ADDRESS: Cumberland Md — DATE SIGNED: 3-31-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Apr 3, 50 — NAME OF CEMETERY OR CREMATORY: St. Peter & Paul's Cem. — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: April 3, 1950 — REGISTRAR'S SIGNATURE: Winter R. Lantz, M.D. — 24. FUNERAL DIRECTOR: Louis Stein, Inc. — ADDRESS: Cumberland

226 X 0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

Dr Johnson

RECEIVED
APR 4 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02289

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) —; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing, Md.; STREET ADDRESS (If rural, give location) 7 Jackson St

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) (Last) Rosenberg

4. DATE OF DEATH: (Month) 3 (Day) 10 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: about 1880

9. AGE last birthday: Abt 70 yrs. If under 1 year: Months — Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Lotharania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harold Fine

14. MOTHER'S MAIDEN NAME: Rose Toovey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service) —

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Isadore Rosenberg - Lonaconing

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary Embolism	3 Days
Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Venous Thrombosis lower extremities	2 wks
	(c)	

466 ✓ 99

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from June, 1946, to Mar. 10, 1950, that I last saw the deceased alive on Mar. 10, 1950, and that death occurred at 7:50 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Arthur F. Jones M.D. — 110 S. Centre St. — Mar. 11, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 3-12-50 — NAME OF CEMETERY OR CREMATORY: East View Cem. — LOCATION (City, town, or county): Cumberland (State): Md.

DATE REC'D BY LOCAL REG.: March 12, 1950 — REGISTRAR'S SIGNATURE: Wm. L. Lantz, M.D. — 24. FUNERAL DIRECTOR: Louis Stein Inc. — ADDRESS: Cumberland

RECEIVED
MAR 21 1950
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

02290

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; LENGTH OF STAY (In this place) 37 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS Philos Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; STREET ADDRESS (If rural, give location) Philos Ave.

3. NAME OF DECEASED (Type or Print): (First) Margaret (Middle) Gray (Last) Rounds

4. DATE OF DEATH: (Month) March (Day) 1 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: July 29-1883

9. AGE last birthday: 66 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Rowlesburg W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gray

14. MOTHER'S MAIDEN NAME: Catherine Louthry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. ---

17. INFORMANT: Arthur Rounds

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute cardiac failure due to — Interval between onset and death: at once

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic myocarditis — about 2 years

422.2 93d

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H.V.Deming M.D. Cumberland Md. March.1-1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Mar 3.1950 — NAME OF CEMETERY OR CREMATORY: Philos Cemetery — LOCATION (City, town, or county) (State): Westernport, Maryland

DATE REC'D BY LOCAL REG: Mar 3/50 — REGISTRAR'S SIGNATURE: Claymaker MD

24. FUNERAL DIRECTOR: E. S. Boal — ADDRESS: Westernport, Md.

RECEIVED
MAR 6 1950
BUREAU U. S.

DR.W.F.WILLIAMS

Within corporate limits

02291

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 21 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) 418 MAGRUDER STREET

3. NAME OF DECEASED (Type or Print)	(First) WILLIAM	(Middle) H.	(Last) SCHAFER	4. DATE OF DEATH	(Month) MARCH (Day) 3, (Year) 1950
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MARCH 13, 1874	9. AGE last birthday 75 yrs.	If under 1 year Months, Days; If under 24 hrs. Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY Jobber Petroleum Industry		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME GEORGE F. SCHAFER			14. MOTHER'S MAIDEN NAME MARY HETZEL		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If year, give war or dates of service) —	16. SOCIAL SECURITY No. None	17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL -CUMBERLAND, MD.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardio Vascular

443 X Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Disease

(c) Hypertension

INTERVAL BETWEEN ONSET AND DEATH: Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-10-, 1950, to 3-3-, 1950, that I last saw the deceased alive on 3/2, 1950, and that death occurred at 4 a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. F. Williams		Cumberland	3/3/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	3-5-50	Rose Hill Cem.	Cumberland	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 5, 1950	Winter R. Frantz, M.D.	Louis Stein Inc	Cumberland Md

338 18

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 14 1950
BUREAU U. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02292

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 23 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 330 Cumberland St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 330 Cumberland St.

3. NAME OF DECEASED (Type or Print): (First) Charlotte (Middle) Ruth (Last) Schlinger

4. DATE OF DEATH: (Month) Mar (Day) 12 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Jan 22, 1920

9. AGE last birthday: 30 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Registered Nurse

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Connellsville Pa

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Albert J. Schlinger

14. MOTHER'S MAIDEN NAME: Myrtle Mowery

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-10-9172

17. INFORMANT AND ADDRESS: Mrs. Myrtle Harley, mother

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Multiple sclerosis	Approx. 4 years
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

345 X
87d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from April, 1946, to March, 1950, that I last saw the deceased alive on March 11, 1950, and that death occurred at 11:30 A.m., from the causes and on the date stated above.

SIGNATURE: W. Alfred Van Orne — (Degree or title) M.D. — ADDRESS: 531 Louisiana Ave., Cumberland, Md. — DATE SIGNED: Mar. 13, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Mar 15, 1950 — NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery — LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: March 14, 1950 — REGISTRAR'S SIGNATURE: Walter L. Mantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: John J. Stofer, Cumberland Md

V3692

RECEIVED
MAR 21 1950
BUREAU V. S.

Within corporate limits

M

02293

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 76 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 215 Franklin St

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Katherine Schmidt
4. DATE OF DEATH (Month) (Day) (Year): Mar 22 1950
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: Mar. 19 1874
9. AGE last birthday: 76 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Seamless
11. BIRTHPLACE (State or foreign country): Cumberland, Md
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Joseph Schmidt
14. MOTHER'S MAIDEN NAME: Magdeline Schellhaus
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No.
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: Mrs Frank Gussman, Cumbd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
174 ×	Immediate cause	(a) Carcinoma of uterus	6 mos.
	Antecedent cause(s)		?
48a	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis, generalized	
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): no
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): no
(CITY OR TOWN) no (COUNTY) (STATE) no
TIME OF INJURY (Month) (Day) (Year) (Hour): no m.
INJURY OCCURRED While at Work ☐ Not While At work ☐: no
HOW DID INJURY OCCUR? no

22. I hereby certify that I attended the deceased from March 7, 1950, to March 22, 1950, that I last saw the deceased alive on March 22, 1950, and that death occurred at 12 45 P.m., from the causes and on the date stated above.

SIGNATURE: Saville G Weisman — (Degree or title): MD — ADDRESS: 122 Bedford St Cumberland Md — DATE SIGNED: 3/23/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: March 25 '50 — NAME OF CEMETERY OR CREMATORY: St Peter & Pauls Cem — LOCATION (City, town, or county): Cumberland (State): Md.
DATE REC'D BY LOCAL REG.: March 24, 1950 — REGISTRAR'S SIGNATURE: Walter L. Frantz, M.D.
24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland

43489

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
MAR 28 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

02294

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart
MARYLAND
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) VICTORIA (Middle) (Last) SCHREIBER

4. DATE OF DEATH: (Month) March (Day) 15, (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 8-16-1867

9. AGE last birthday: 82 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Danzig, Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Kersenky

14. MOTHER'S MAIDEN NAME: Mary Dietze

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Bernard Schreiber, Eckhart, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) arteriosclerosis — Interval Between Onset and Death: several years

450.0 Antecedent cause(s)

97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1944, 19..., to Mar 15, 1950, that I last saw the deceased alive on Mar 10, 1950, and that death occurred at 8:00 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Wm McLane M.D. ADDRESS: Frostburg Md DATE SIGNED: 3-17-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 3-18-1950
NAME OF CEMETERY OR CREMATORY: St. Michaels Cemetery
LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 3-18-50
REGISTRAR'S SIGNATURE: Wm. Nancy K. Roe

24. FUNERAL DIRECTOR: J. R. Durst, ADDRESS: Frostburg, Md.

RECEIVED
AUG 21 1950
BUREAU

Within corporate limits R. Williams

02295

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Oldtown
STREET ADDRESS (If rural, give location): Main St.

3. NAME OF DECEASED (Type or Print): (First) Carrie (Middle) A (Last) Shanholtz

4. DATE OF DEATH: (Month) Mar. (Day) 13 (Year) 1950

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 22 1881
9. AGE last birthday: 68 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Post Mistress
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Oldtown Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael Skelley
14. MOTHER'S MAIDEN NAME: Virginia Farlow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Ct. — (If year, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: Florence Skelley, Old Town

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 48 hrs

443 Antecedent cause(s) Arteriosclerotic Hypertensive — Unknown

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) C.V.D.

(c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): — (CITY OR TOWN) Cumberland (COUNTY) Alleg. (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 2/6/48, 19....., to 3/13/50, 19....., that I last saw the deceased alive on 3/13/50, 19....., and that death occurred at 7 p.m., from the causes and on the date stated above.

SIGNATURE: R. Williams (Degree or title) MD — ADDRESS: Cumberland — DATE SIGNED: 3/14/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: March 16 50 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cem — LOCATION (City, town, or county): Cumberland (State): Md

DATE REC'D BY LOCAL REG.: March 15, 1950 — REGISTRAR'S SIGNATURE: Arnold R. Frantz, M.D. — 24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: " — X

26645

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
MAR 21 1950
BUREAU V. S.

Within corporate limits

02296

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 75 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1112 Bedford St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 1112 Bedford St.

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Louise Willison (Last) Simpson
4. DATE OF DEATH (Month) March (Day) 13 (Year) 1950
5. SEX Female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Nov.5-1874
9. AGE last birthday 75 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Flintstone Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Hillary F. Willison
14. MOTHER'S MAIDEN NAME Elmira Hendrickson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Charles J. Simpson (husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute cardiac failure	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary embolus	at once
	(c)	

420.1
186a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
(CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) July (Day) 30/49 (Year) about 3 (Hour) P. m.
INJURY OCCURRED While at work ☒ Not while at work ☐ at home
HOW DID INJURY OCCUR? Lost her balance going down stairs, fractured right femur.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED March 13-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Mar 16 1950
NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery
LOCATION (City, town, or county) Cumberland, Md. (State)
DATE REC'D BY LOCAL REG. March 15, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz. M.D.
24. FUNERAL DIRECTOR William H. Kight, ADDRESS Cumberland, Md.

900.0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
MAR 21 1950

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02297

FILM No. G 124 MAR 21 1950

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (In this place) 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) West Main St

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Esther	Jemiles	Smith	May	11th	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widowed	Aug 16 1866	83 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper	Own home	Barton, Md	U. S. A

13. FATHER'S NAME: Samuel Jeffries
14. MOTHER'S MAIDEN NAME: Susan Hocking

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Charles S. Jeffries

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X **Immediate cause** (a) Cerebral Hemorrhage — Interval between onset and death: 6 wks.

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Hypertension Cardio-Vascular disease. —
(c) Senility.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Mar 1, 1950, to Mar 11, 1950, that I last saw the deceased alive on Mar 11, 1950, and that death occurred at 4:55 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H. C. Diehl	M. D.	Frostburg, Md.	3/13/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Mar 14 1950	Allegany Cemetery	Frostburg	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3-14-50	Mrs. Nancy N. Roe	W. Eichhorn	Lonaconing, Md.

VS. A15

RECEIVED
MAR 16 1950
BUREAU V. S.

Within corporate limits

DR. W. F. WILLIAMS

02298

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: WEST VIRGINIA COUNTY: HARDY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place): 4 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: MOOREFIELD
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL Hospital	STREET ADDRESS (If rural, give location): ✓

3. NAME OF DECEASED (Type or Print)	(First) BETTY	(Middle) LOU	(Last) SOUTHERLY	4. DATE OF DEATH	(Month) MARCH (Day) 18 (Year) 1950
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE	8. DATE OF BIRTH: DEC. 2, 1936	9. AGE last birthday: 13 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student	10b. KIND OF BUSINESS OR INDUSTRY: School	11. BIRTHPLACE (State or foreign country): WEST VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: JOHN SOUTHERLY	14. MOTHER'S MAIDEN NAME: VIRGINIA D. BURNS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT AND ADDRESS: MEMORIAL - CUMBERLAND, MARYLAND.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Poliomyelitis	Said to be 2 wks.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

080.3

36

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-14, 1950 to 3-18, 1950, that I last saw the deceased alive on 3-18-50, 1950, and that death occurred at 9:00 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. F. Williams		Cumberland	3/18/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Mar 21-1950	Walnut Bottom	Hardy County	W. Va

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 19, 1950	Wrnter R. Frantz, M.D.	A. C. Ruckman	Romney W. Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 28 1950
BUREAU Y. S.

Dr. McLane
02299

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital	STREET ADDRESS (If rural, give location): Consol Village

3. NAME OF DECEASED (Type or Print)	(First) ALICE	(Middle) VIRGINIA	(Last) SPIKER	4. DATE OF DEATH	(Month) March (Dey) 21 (Yeer) 1950
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed	8. DATE OF BIRTH: 9-27-1860	9. AGE last birthdey: 89 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Lonaconing, Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: William Moore	14. MOTHER'S MAIDEN NAME: Emily Metz				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.: none	17. INFORMANT AND ADDRESS: Mrs. John Porter, Frostburg, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X Immediate cause (a) Cerebral Hemorrhage — 8 hrs

Antecedent cause(s) R + Hemiplegia

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio Sclerosis — Several years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 21, 1950, to Mar 21, 1950, that I last saw the deceased alive on Mar 21, 1950, and that death occurred at 6:40 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W O McLane MD		Frostburg Md	3-22-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 3-24-1950	NAME OF CEMETERY OR CREMATORY: Allegany Cemetery	LOCATION (City, town, or county) (State): Frostburg, Md.
DATE REC'D BY LOCAL REG.: 3-24-50	REGISTRAR'S SIGNATURE: Mrs Nancy H Roe	24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 29 1950
BUREAU OF S.

02390

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ocean
LENGTH OF STAY (in this place): Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ocean
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Bridget (Last) Stakem

4. DATE OF DEATH: (Month) March (Day) 16 (Year) 19 50

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Nov 5, 1872

9. AGE last birthday: 77 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Stakem

14. MOTHER'S MAIDEN NAME: Margaret Kenny

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Margaret Stakem

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

450.0 **Immediate cause** (a) Heart failure — 1 week

97 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis — 2

(c)

161 X

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. cachexia (possible cancer of larynx) — 1 year

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-16, 1950, to 3-16, 1950, that I last saw the deceased alive on 3-16, 1950, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

SIGNATURE: Adolf Volkman (Degree or title) M.D. ADDRESS: Frostburg DATE SIGNED: 3-18-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Mar 20, 1950 — NAME OF CEMETERY OR CREMATORY: St Michaels Cemetery — LOCATION (City, town, or county) (State): Frostburg Md.

DATE REC'D BY LOCAL REG. 3-20-50 — REGISTRAR'S SIGNATURE: Jeannette M Pool

24. FUNERAL DIRECTOR: M. Eichhorn — ADDRESS: Lonaconing, Md.

VS-A15

RECEIVED
MAR 30 1950
BUREAU

Within corporate limits Dr Rich Wms

02301

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 27 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 522 City View Terrace

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 522 City View Terrace

3. NAME OF DECEASED (Type or Print) (First) Bessie (Middle) Burgess (Last) Statler

4. DATE OF DEATH (Month) Mar (Day) 11 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Aug 22, 1882
9. AGE last birthday 67 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Shaft, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Richard J. Chaney
14. MOTHER'S MAIDEN NAME Margaret Bawden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS Chas Statler, Rt I Allegany Grove

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of breast — INTERVAL BETWEEN ONSET AND DEATH 4 yrs

170 X

Antecedent cause(s)

50

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) Cumberland (COUNTY) Alleg (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 3/15/46, 19....., to 3/11/50, 19....., that I last saw the deceased alive on 3/11/50, 19....., and that death occurred at 1:15 P. m., from the causes and on the date stated above.

SIGNATURE R. H. Williams (Degree or title) MD ADDRESS Cumberland, Md DATE SIGNED 3/13/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Mar 14, 1950
NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. March 14, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 21 1950
BUREAU V. S.

Evidence for change of age shown on:

02302

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FILM No. G 124 MAR 21 1950

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 1 week
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural give location) -

3. NAME OF DECEASED (Type or Print) (First) John (Middle) F (Last) Steele
4. DATE OF DEATH (Month) March (Day) 13 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH May 14, 1869
9. AGE last birthday 80 ~~81~~ yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner
10b. KIND OF BUSINESS OR INDUSTRY Coal Mine
11. BIRTHPLACE (State or foreign country) Scotland
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME John Steele
14. MOTHER'S MAIDEN NAME Felins
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT James Steele

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Broncio pneumonitis — INTERVAL BETWEEN ONSET AND DEATH 1 wk.

491X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

107

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/6, 1950, to 3/13, 1950, that I last saw the deceased alive on 3/13, 1950, and that death occurred at 8:20 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Paul Eugene Inge, M.D. — Lonaconing Md 3/14/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF March 15, 1950
NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery
LOCATION (City, town, or county) Lonaconing, (State) Md

DATE REC'D BY LOCAL REG. 3-14-50
REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe
24. FUNERAL DIRECTOR M. Eichhorn ADDRESS Lonaconing, Md

454

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 16 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

02303

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (in this place): 70 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 633 Columbia Ave	STREET ADDRESS (If rural, give location): 633 Columbia Ave

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Andrew	Bernard	Swankhaus	March	13	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	white	single	May 15-1879	70 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired Glazer,	Potomac Glass Co.	Cumberland Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Swankhaus	Katherine Schindler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	none	Mrs. Joseph Felten

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral hemorrhage (apoplexy)	a few min.
442 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis with hypertention	about 2 years
131a	(c) Cardio-vascular-renal disease.	?
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.	Cumberland Md.	March 13-1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	March 15, 50	SS. Peter & Paula	Cumberland Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 14, 1950	Winter L. Frantz, M.D.	Lewis Stein Inc.	Cumb. Md.

VS. A15A

44625

RECEIVED
MAR 21 1950
BUREAU V

Dr. McLane

02304

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 5 Weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 113 E. Main St.

3. NAME OF DECEASED (Type or Print) (First) LUCY (Middle) MAY (Last) THOMPSON
4. DATE OF DEATH (Month) March (Day) 27, (Year) 1950

5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH 6-8-1876
9. AGE last birthday 73 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jacob Lafferty
14. MOTHER'S MAIDEN NAME Mary Meyers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT AND ADDRESS Mrs. Catherine LaPorta, Frostburg, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.2 Immediate cause (a) Chr. Myocarditis — 6 mo

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1950, to Mar. 27, 1950, that I last saw the deceased alive on Mar. 27, 1950, and that death occurred at 3:15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W. McLane MD Frostburg Md 3-28-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 3-30-1950
NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery
LOCATION (City, town, or county) (State) Frostburg, Md.

DATE REC'D BY LOCAL REG. 3-29-50
REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe
24. FUNERAL DIRECTOR ADDRESS J. R. Durst, Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 3 1950
BUREAU V. S.

Write in corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02305

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A5

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, — LENGTH OF STAY (in this place) 26 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
HOSPITAL OR INSTITUTION OR STREET ADDRESS 228 Union St.,	STREET ADDRESS (If rural, give location) 228 Union St.,

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	GRACE	BLANCHE	TURNER	Mar.	13,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Married	July 2, 1882	67 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Deerpark, Md.	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Goff	Isabell Sowers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No		None	Kathleen Turner 228 UnionSt., Cumb.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinoma (adeno) of uterus	2½ yrs
174 X Antecedent cause(s)		
48 L Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 48, to Jan. 13, 1950, that I last saw the deceased alive on Jan. 11, 1950, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M.D.	110 S. Centre St.	Jan. 14, 1950

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Mar. 16, 1950	Mt. Herman	Near Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 16, 1950	Walter L. Hauk, M.D.	Charles L. George	Cumberland, Md.

RECEIVED
MAR 21 1950
BUREAU OF

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02306

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place) 2 Months
HOSPITAL OR INSTITUTION OR STREET ADDRESS 711 Shriver Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pennsylvania — COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Buffalo Mills
STREET ADDRESS (If rural, give location) Rural ✓

3. NAME OF DECEASED (Type or Print): (First) Harriett (Middle) Jane (Last) Turner

4. DATE OF DEATH: (Month) March (Day) 1 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Jan. 10 1868

9. AGE last birthday: 82 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Bedford Co. Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George Sheirer

14. MOTHER'S MAIDEN NAME: Sara Stoltzman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Harvey May

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Uremia — 1 week

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Nephritis, generalized Arteriosclerosis

(c) Heart Disease

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1, 1949 to March 1, 1950, that I last saw the deceased alive on March 1, 1950, and that death occurred at 1.0 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

B. M. Schindler M.D. — 41 Emerald, Cumberland, Md. — March 3 1950

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 3/4/50 — NAME OF CEMETERY OR CREMATORY Dry Ridge Cemetery — LOCATION (City, town, or county) Mapps Choice (State) Pa. R.D.1.

DATE REC'D BY LOCAL REG. March 3, 1950 — REGISTRAR'S SIGNATURE Winter L. Hartz M.D. — 24. FUNERAL DIRECTOR Harvey N. Teegley — ADDRESS Hyndman Pa.

VS. A15

RECEIVED
MAR 7 1950
BUREAU V. S.

DR. DYER

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02307

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND,
LENGTH OF STAY (in this place) 10 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 330 ESTELLA STREET

3. NAME OF DECEASED (Type or Print): (First) GIBSON (Middle) (Last) TWYMAN

4. DATE OF DEATH: (Month) MARCH (Day) 8, (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: COLORED

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: MARCH 18, 1886

9. AGE last birthday: 63 yrs. — If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: Public Bldg

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: LUM GIBSON TWYMAN

14. MOTHER'S MAIDEN NAME: Mary ~~MARY~~ ~~CARY~~ Clay

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Ent — (If year, give war or dates of service)

16. SOCIAL SECURITY NO. 217-10-1894

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL -CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	10 days
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardiovascular disease	4 yrs.
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Syphilis - late	20 yrs

4437
309
0264

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-26-, 1950, to 3-8-, 1950, that I last saw the deceased alive on 3-8-, 1950, and that death occurred at 5:05 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John A Dyer, M.D. 247 Va ave 3-8-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: March 11th 1950 | NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery | LOCATION (City, town, or county) (State): Cumberland Maryland

DATE REC'D BY LOCAL REG.: March 11 1950 | REGISTRAR'S SIGNATURE: Winter R. Dantz, M.D. | 24. FUNERAL DIRECTOR: Louis Stein, Inc. | ADDRESS: Cumberland, Md.

740-83

RECEIVED
MAR 14 1950
BUREAU V. R.

Within corporate limits

02308

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 1 Year	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 505 Bedford Street	STREET ADDRESS (If rural, give location): 505 Bedford Street

3. NAME OF DECEASED (Type or Print)	(First) Helen	(Middle)	(Last) Tyler	4. DATE OF DEATH	(Month) March (Day) 9 (Year) 1950
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: Dec 9 1859	9. AGE last birthday: 90 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife	10b. KIND OF BUSINESS OR INDUSTRY: House	11. BIRTHPLACE (State or foreign country): Snowden, Virginia	12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME: James Hobson	14. MOTHER'S MAIDEN NAME: Mary Pemberton				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service): No	16. SOCIAL SECURITY NO.: None	17. INFORMANT AND ADDRESS: A.R.Tyler, 505 Beford St, Cumberland Maryland			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiovascular Disease — years.

422.1 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized arteriosclerosis — years.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1949, to March 9, 1950, that I last saw the deceased alive on March 9, 1950, and that death occurred at 4:15 P.m., from the causes and on the date stated above.

SIGNATURE: B. M. Schindler (Degree or title) MD. ADDRESS: 41 Greenett, Cumberland, Md. DATE SIGNED: March 10, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: March 12, 1950	NAME OF CEMETERY OR CREMATORY: Allegany Cemetery	LOCATION (City, town, or county) (State): Frostburg, Md.
DATE REC'D BY LOCAL REG.: March 11, 1950	REGISTRAR'S SIGNATURE: Winter R. Frantz M.D.	24. FUNERAL DIRECTOR: William H. Kight, Cumberland, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 14 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02309

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): 16 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
STREET ADDRESS (If rural, give location): Foundry Row

3. NAME OF DECEASED (Type or Print): (First) FRANK (Middle) T. (Last) VANN

4. DATE OF DEATH: March 16, 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 12-12-1857

9. AGE last birthday: 92 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired blacksmith

10b. KIND OF BUSINESS OR INDUSTRY: B&O RR

11. BIRTHPLACE (State or foreign country): Liberty Furnace, Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Abraham Vann

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Howard Sine, Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial Failure — Interval Between Onset and Death: 3 weeks

592 Antecedent cause(s) (b) Chronic Interstitial Nephritis — several years

131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Age & Senile Debility — Many years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour):

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-27, 1950, to 3-16, 1950, that I last saw the deceased alive on 3-16, 1950, and that death occurred at 9:20 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): William E. Marley — ADDRESS: Mt Savage, Md. — DATE SIGNED: March 18-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 3-19-50 — NAME OF CEMETERY OR CREMATORY: Barb Cemetery — LOCATION (City, town, or county) (State): Woodstock, Va.

DATE REC'D BY LOCAL REG.: 3-18-50 — REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR — ADDRESS: J. R. Durst, Frostburg, Md.

302.47

RECEIVED
NOV 21 1950

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

02310

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 78yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 529 Fayette St.

3. NAME OF DECEASED (Type or Print): (First) Theodore (Middle) A. (Last) Wallace

4. DATE OF DEATH: (Month) 3 (Day) 8 (Year) 50 19

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 9/8/1873

9. AGE last birthday: 76 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Conductor

10b. KIND OF BUSINESS OR INDUSTRY: Steam Railroad

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James J. Wallace

14. MOTHER'S MAIDEN NAME: Anna Granlich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-10-8553

17. INFORMANT AND ADDRESS: Mrs. Harry F. Rizer Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Broncho Pneumonia	72 hrs
9020 Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 1860	(b) Fracture Lft humerus	6 days
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.): Home — (CITY OR TOWN) Cumberland (COUNTY) Alley (STATE) Md

TIME OF INJURY (Month) 3 (Day) 8 (Year) 50 (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR? Pt fell out of bed

22. I hereby certify that I attended the deceased from 2/16/45, 19..., to 3/8/50, 19..., that I last saw the deceased alive on 3/8/50, 19..., and that death occurred at 9:55 P m., from the causes and on the date stated above.

SIGNATURE: W Wilhelm (Degree or title) M.D. ADDRESS: Cumberland DATE SIGNED: 3/9/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 3/11/50

NAME OF CEMETERY OR CREMATORY: St Peter & Paul's Cem

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: March 10, 1950

REGISTRAR'S SIGNATURE: Walter L. Kantz, M.D.

24. FUNERAL DIRECTOR: James F. Scarpelli ADDRESS: Cumberland Md

10247

RECEIVED
MAR 14 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02311

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cooperstown; LENGTH OF STAY (In this place) Lifetime; HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 1 Frostburg, Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cooperstown; STREET ADDRESS (If rural, give location) Route 1 Frostburg, Md

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) Emily (Last) Wampler

4. DATE OF DEATH: (Month) 3 (Day) 28 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 4-6-1885

9. AGE last birthday: 64 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Cooperstown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Bluebaugh

14. MOTHER'S MAIDEN NAME: Mary Miscovar

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs John T. Bantus Jr. Vale Summit Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

481 Immediate cause (a) Acute Myocarditis — Interval Between Onset and Death: 3 mos

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Influenza — Jan 1950

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 2, 1950 to Mar 28 1950, that I last saw the deceased alive on Mar 28, 1950, and that death occurred at 12:15 P m., from the causes and on the date stated above.

SIGNATURE: W M Lane M D (Degree or title) ADDRESS: Frostburg Md DATE SIGNED: 3-29-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 3-31-1950 — NAME OF CEMETERY OR CREMATORY: Vale Summit Methodist — LOCATION (City, town, or county) (State): Vale Summit Md.

DATE REC'D BY LOCAL REG. 3-31-50 — REGISTRAR'S SIGNATURE: Mrs. Daisy K. Roe

24. FUNERAL DIRECTOR: Jacob Hafer, Frostburg, Md. — ADDRESS:

for Mr. Lane

RECEIVED
APR 5 1960
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

02312

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (In this place): 71 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 13 Harrison St.	STREET ADDRESS (If rural, give location): 13 Harrison St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	W.	Warner	March 2 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
male	white	single	March-5-1878	71 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired) machinest Skilled	B&O.R.Ry.	Cumberland Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Lewis Warner	Elizabeth Wolf

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no		Mrs. Fannie Robbison

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	several years.
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V. Deming M.D.	Cumberland Md.	March 2-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Mar. 4, 1950	Rose Hill	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 4, 1950	Walter L. Lantz, M.D.	Charles L. George	Cumberland, Md.

32647

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MAR 7 1950
BUREAU V. S.

Within corporate limits? DR. ROBINSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02313

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 11 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: FROSTBURG, Rural
STREET ADDRESS (If rural, give location): BOX 268

3. NAME OF DECEASED (Type or Print): (First) PHYLLIS (Middle) (Last) WHITEFIELD

4. DATE OF DEATH: (Month) MARCH (Day) 7 (Year) 1950

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: JULY 23, 1935

9. AGE last birthday: 14 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STUDENT

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JAMES WHITEFIELD

14. MOTHER'S MAIDEN NAME: EVELYN DENNISER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Memorial Hospital, Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Rheumatic Heart Disease with failure

416X Antecedent cause(s)

95b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION**

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | **PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Mooth) (Day) (Year) (Hour) m. | **INJURY OCCURRED** While at Work ☐ Not While At work ☐ | **HOW DID INJURY OCCUR?**

22. I hereby certify that I attended the deceased from Feb 24, 1950, to March 7, 1950, that I last saw the deceased alive on Feb 24, 1950, and that death occurred at 6:35 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
March 7 Thomas Robinson	M.D.	195 Liberty St. Cumberland, Md	3/8/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	March 10, 1950	Allegany Cemetery	Frostburg, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 8, 1950	Walter R. Frantz, M.D.	Jacob Hafer	Frostburg, Md

Frostburg 65

VS-A15

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MAR 14 1950
BUREAU V. S.

DR. W.F.WILLIAMS

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02314

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 13 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 732 MARYLAND AVENUE

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
FLORA	MAE	WILSON	MAR.	18	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
FEMALE	WHITE	MARRIED	JULY 5, 1870	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME THOMAS CRAWFORD
14. MOTHER'S MAIDEN NAME [redacted]H ANN DAVIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS MRMORIAL HOSPITAL, MEMORIAL AVENUE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

4424 Immediate cause (a) Cardio Vascular

Antecedent cause(s)

1310 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Renal Disease (Uremia)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 1-17, 1944, to 3-18, 1950, that I last saw the deceased alive on 3-18, 1950, and that death occurred at 5:12 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W.F. Williams	M.D.	Cumberland	3/20/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Mar. 21, 1950	Rose Memorial	Near Cumberland	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 20, 1950	Walter K. Hantz, M.D.	James F. Scarpelli, Cumberland, Md.	

VS. A15

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MAR 28 1950
BUREAU V. S.

Dr Diehl

02315

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg | LENGTH OF STAY (In this place): 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg - Star route
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) LAURA (Middle) (LAYTON) (Last) WINBRENNER

4. DATE OF DEATH: (Month) March (Day) 28, (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: 1-31-1874

9. AGE last birthday: 76 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: Belle Layton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Roy Winbrenner, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

174 Immediate cause (a) Carcinoma of uterus. — Interval between onset and death: 1 1/2 yrs.

Antecedent cause(s)

148a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arterio - sclerosis.

(c) Chronic myocarditis.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Colloid goitre (non-toxic).

19a. DATE OF OPERATION: none | 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1948, to 3-28, 1950, that I last saw the deceased alive on 3-28, 1950, and that death occurred at 9:45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS — DATE SIGNED

H. C. Diehl, M.D. Frostburg Md. — 3-29-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 3-31-1950 | NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery | LOCATION (City, town, or county) (State): Garrett County, Md.

DATE REC'D BY LOCAL REG. 3-29-50 | REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe | 24. FUNERAL DIRECTOR ADDRESS: J. R. Durst, Frostburg, Md.

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APR 3 1950
BUREAU F. S.